OHIO FAMILY AND CHILDREN FIRST

Service Coordination

Service Coordinator Handbook

June 30, 2022

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Ohio Family and Children First Partners:

We are so very pleased to be able to present this handbook to you, which is a culmination of many hours of hard work by many individuals, including: county Family and Children First Councils who volunteered their time to attend meetings, edit documents, and provide feedback to ensure we have their "boots on the ground" experience; stakeholders who are invested in the work of family and children first councils and were able to provide their perspective on how we can best support councils in their critical work; the Child and Adolescent Behavioral Health Center of Excellence, our vendor, who provided the expertise and the infrastructure necessary to help us write and assemble this living document; and finally, the Ohio Family and Children First staff who worked to ensure this very important deliverable was initiated and carried through to completion.

As a state, we have navigated the pandemic and other critical changes to our landscape. However, that path forward has not been without challenges, and a need to identify practices that help us best serve our children and families, some of whom are struggling now more than ever. To that end, we heard the request from our county Family and Children First Councils to provide more support and consistency, and completion of this handbook is the first of many steps towards achievement of that goal.

We hope you find this handbook helpful in guiding and enhancing the important work you do each and every day. You are critically important to the well-being of children and families of Ohio, and we thank you.

Elisha R. Cangelosi, MSW, LISW-S
Executive Director, Ohio Family and Children First

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Ohio Family and Children First

History of the Office of Family and Children First (OFCF)

Ohio has a long history of coordinating services and systems to address the needs of youth and families. In the mid-eighties stakeholders around the state identified a significant problem in meeting the needs of youth and their families, who were involved in multiple systems.

In 1987, Governor Celeste brought child serving agencies together to form the Interdepartmental Cluster Services For Youth (ICSFY), often referred to as “Cluster”. Counties were mandated to form ICSFYs. Much of the focus was on youth with very intense needs requiring out-of-home placements.

The teams typically consisted of child service personnel from the different agencies and systems involved with the child. The team would formulate a treatment plan for the child and determine how the services would be funded. State Intersystem Cluster Funding was created to assist counties in providing services/placements for youth for which funding was not otherwise available.

In the early 1990s Governor Voinovich created county FCFCs to expand the work of Cluster and become the catalyst for bringing communities together to coordinate and streamline services for families and youth. County FCFCs were established in ORC 121.37 in 1993, along with a blueprint of how the coordination of services and systems should operate at the state and local level, including the service coordination mechanism.

In 2006, during the Taft Administration, ORC 121.37 was changed to include high risk youth participating in the Service Coordination Mechanism (SCM) and to divert them from the juvenile court system. Other changes focused on family voice and choice and family engagement and empowerment.

In 2010, during the Strickland Administration, county FCFCs were required to update their county Service Coordination Mechanism to reflect current practice and ensure compliance with the ORC. The state’s Family Centered Services and Supports (FCSS) Initiative was connected to county FCFC service coordination and offered funding for non-clinical services and supports, including service coordination, for families and their youth.

Under the Kasich Administration in 2018, county FCFCs were required to revise their local Service Coordination Mechanism and to further clarify their System of Care. Specific clarifications included: target populations, levels of intervention, data collection and monitoring and how data is used to inform decision making at the macro level. For the first time ever, distinctions between county FCFC Service Coordination and High Fidelity Wraparound were made in Ohio’s SCM Guidance Document.

In 2019, Governor DeWine created the Office of Children’s Initiatives to coordinate and align the state’s children’s programming, advance policy, and innovation in programming

for youth, and to provide support services for all youth and their families. This initiative was connected to county FCFC service coordination and offered funding for non-clinical services and supports, including service coordination, for families and their youth.

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Current Structure and Purpose of OFCF

OFCF's vision is for *every child and family to thrive and succeed within healthy communities.*

OFCF is a partnership of state and local governments, communities, and families.

OFCF's mission is to *enhance the well-being of Ohio's children and families by building community capacity, coordinating systems and services, and engaging families.*

OFCF Cabinet Council and county FCFCs have operationalized the statute in a variety of ways. The OFCF Cabinet Council is composed of the following Ohio Departments: Aging, Developmental Disabilities, Education, Health, Job and Family Services, Medicaid, Mental Health and Addiction Services, Opportunities for Ohioans with Disabilities, Rehabilitation and Correction, Youth Services, and the Office of Budget and Management.

ORC 121.37 outlines the core functions for OFCF Cabinet Council and county FCFCs, which includes four mandated core functions: coordinating systems and services, building community capacity, shared accountability, and engaging and empowering families.

Governor's Children's Initiative

Governor DeWine's Children's Initiative included passage of HB 161 in 2019 to accomplish several policy goals and to provide funding to support these policies, particularly around Multi-System Youth (MSY). The main goals are to prevent custody relinquishment for families solely for the purpose of obtaining treatment, ensure county systems have the resources and planning processes in place to prevent youth from entering residential care,

when possible, and ensure these youth transition successfully from a residential treatment setting to a community treatment setting.[1]

Ohio's Family and Children First Cabinet Council was tasked with developing a MSY Action Plan. They established a committee and six working groups to conduct research and develop recommendations for a final report, which was completed in January 2020.

The Center for Innovative Practices (CIP) has assisted in implementing several recommendations that resulted from this report, particularly in the areas of HFWA and modernization of county FCFCs.

Modernization of county FCFCs includes helping counties adopt and become proficient in the use of HFWA as their planning process for MSY youth and providing training and technical assistance to counties to build capacity and develop the infrastructure needed to support new initiatives.

This Service Coordinator Handbook is the result of efforts to modernize county FCFCs.

[1] Rule 5101:9-6-24 | Multi-system youth (MSY) funding. Ohio Administrative Code/5101:9/Chapter 5101:9-6 | Allocations, https://codes.ohio.gov/ohio-administrative-code/rule-5101:9-6-24

Service Coordination Function

Service Coordination Mechanism

In Ohio, county FCFCs use service coordination to help plan and organize services for families and youth. Each county is required to develop a Service Coordination Mechanism (SCM). The SCM must be consistent with requirements of the Ohio Revised Code (ORC) 121.37 (C)(D) and 121.38.

The county SCM is the guiding document for coordination of services when a youth with complex, multi-system needs is referred to the county FCFC. All persons or entities providing service coordination on behalf of the county FCFC, whether county FCFC employees or contracted providers, must follow the processes, policies, practices, and procedures as they are outlined and described in the county FCFC Service Coordination Mechanism.

All counties provide Service Coordination and many counties also provide High-Fidelity Wraparound (HFWA). Service coordination and HFWA are collaborative, coordinated, cross-system team-based planning processes implemented to address the needs of youth and families where those needs are multiple and complex.

How To Develop a County SCM

The Service Coordination Mechanism Guidance (SCM) offers suggestions and provides tools for developing the county Service Coordination Mechanism. The mechanism must be developed and approved by the county Council and OFCF. Additional community partners such as local mental health agencies, schools, Children's Hospitals, Metropolitan Housing, and others have ongoing involvement in the development of the SCM. This is a living document and it is best practice to review the SCM annually.

Service Coordination Planning Process

The purpose of Service Coordination and High-Fidelity Wraparound through the county FCFC is to provide a venue for families and youth with multiple, complex needs to develop a creative, strengths-based family centered plan that meets the needs of the family and youth. These processes are for youth needing more extensive collaboration with multi-system providers.

The county FCFC Service Coordination process is an integral component of a local system of care, which is family driven, youth guided, culturally competent and community based. It is a process of service planning and system collaboration that coordinates individualized services and supports to families who have needs across multiple systems.

The System of Care: Family-Centered Services and Supports Funding

Family-Centered Services and Support (FCSS) funds may be used by youth with multi-system needs, who are receiving service coordination through the county FCFC. FCSS funds are designed to meet the unique non-clinical needs of youth and families identified on the individualized family service coordination plan. For more information about the FCSS funds, see System of Care: FCSS Guidance.

County FCFC Service Coordination Flow Chart

Referral Received

- Referral for Service Coordination received by county Family and Children First Council (FCFC).
- FCFC Director or Service Coordinator reviews referral for eligibility as stated in county Service Coordination Mechanism.
- Family is determined eligible and a coordinator/facilitator is assigned or the family is placed on a wait list (if applicable) and is connected to alternative services and supports **OR** ineligible and is connected to alternative services and supports.

Meeting with Family

- Coordinator meets with family to complete the following:
  - Gather family's story
  - Assess for needs and strengths
  - New or updated initial assessments (such as the Child and Adolescent Needs and Strengths assessment)
  - Essential forms (e.g. Release of Information, Dispute Resolution Process)
- Coordinator reviews gathered information to determine, either individually or in review with the county FCFC or appropriate subcomittee, the most appropriate planning and support model to implement with the family (i.e. Service Coordination process or High Fidelity Wraparound)

Implementation of Planning and Supports

- Coordinator begins implementing either the Service Coordination process (as delineated in the county Service Coordination Mechanism) or the High Fidelity Wraparound model as delineated by the National Wraparound Initiative (NWI).
- At minimum Coordinator will:
  - Work with the family to develop a team
  - Facilitate team meetings to create an Individualized Family Service Plan (IFSP) Plan of Care designed to meet the family's determined goals and needs.
  - Monitor the impact and effectiveness of the IFSP Plan of Care and update the plan as needed, but at least every 90 days
  - Update/complete on-going assessments as needed, but at least every 90 days.
  - Upon completion of model, Coordinator transitions family to next appropriate level of care and support.
  - Complete Exit Survey

Service Coordination Standard Operating Procedures: Tools for Family Centered Care

Navigating complex public systems to find the right help for your family can be a challenging experience. Some parents have reported that going through systems feels a bit like riding a roller coaster. Just when things seem to be getting smoother, it feels like there's another loop or curve when you find out that your family doesn't fit, or the service wasn't what you thought it was or that you are no longer eligible. Families who enter public service systems are on a journey. Some families will experience that journey as moving away from something or moving to something. In the former, families may say they want the challenge or frustration to end. That family journey often feels most like an evacuation or an escape. In other settings, families come to public services because they want something to happen and believe that it can. In those cases, navigating public systems can feel more like planning for a trip that once you get there you expect to enjoy.

Whenever we think about families who end up at the front door of a county FCFC and are in need of either Service Coordination or the Wraparound Planning process, it's helpful to consider that we get to go with families on their journey from *Hello* to *Healing*. This framework serves as the outline for both Service Coordination and the Wraparound Process. Framing it this way holds the promise of staying absolutely focused on the experience of the families we get to serve, no matter whether we are following the Service Coordinator or Wraparound Road Maps. When using this framework, we recognize the feeling that families get from an encounter is the same whether we follow Wraparound or Service Coordination. Thinking about either process around the family's experience is described below:

- ***Hello***: All families deserve to feel welcomed. Service Coordinators or Wraparound Facilitators should remember that from the other side of the counter, it all starts with a warm welcome. Staff should seek to communicate their interest in the family and their commitment to building a thorough understanding of their experience. Activities in this area are not about engaging families in our process but instead communicating our sense of interest in the family's experience so that we can position ourselves to go with each family on a journey that is most helpful for them.
- ***Help***: All families deserve a sense of expectancy. Once a staff member has established that warm welcome, they should be prepared to help families get to the right help, provided in the right way to produce the right result, in the shortest amount of wait time. While both Service Coordinators and Wraparound Coordinators often host meetings that bring people together, the point of this is not to host a meeting. Instead, it's about making sure that families feel that they've been heard and that we can help them find and link with people, programs, resources, and things that are going to address their concerns. Not every family will find every option helpful. Every Service Coordinator should be open to partnering with a family until they find the right response that creates a sense of what is most helpful for the family.

- ***Healing**:* All families deserve to know that their situation is improving. Once help has been negotiated, Service Coordinators and county FCFC Wraparound Coordinators will follow the process of accessing help over time to ensure that families have access to the results they deserve. Service Coordinators/Wraparound Facilitators check with families and others over time to ensure that not only are we providing a resource but that it is making a difference. If the resource, intervention or support isn't working, they should be changed. Maintaining a focus on that outcome and keeping the team together working towards results takes the most time in either Service Coordination or Wraparound Facilitation.
- ***Hope**:* All families have a right to hope that guides their experience and life. As family, staff and communities work together over time, families should see they can look forward to the future with a sense of expectancy. Coordinators work with families and team members to set targets for what life will look like and continue these efforts through the last minute of connection, and a formal team is no longer needed. The Coordinator introduces the concept of transition to a hope filled life, works with the family and team to be specific about what those elements look like and guides the team in moving towards that target. At this stage, families should feel an increased sense of confidence that things can work out as well as a sense of competence or skill that they can handle bumps in the road. The Coordinator works to ensure the family has a sense of connection to community, system, family, or support resources that they can access, if necessary, in the future.

It's not about engaging a family into our process but instead how we can meet families and arrange system and community resources to help them move to *Hope*. *Hope* relates to increased engagement. *Hope* associates with better service outcomes. *Hope* builds family resiliency. *Hope* is everything for families who find themselves navigating complex systems. County FCFCs work with families to ensure that their time in systems is driven by the family and not the system. This is true whether the road map leads one to Service Coordination or Wraparound.

Establishing Referrals within County FCFCs

Rule: O.R.C. 121.37(C)(1) Each county service coordination mechanism shall include "A procedure for an agency, including a juvenile court, or a family voluntarily seeking service coordination, to refer the child and family to the county council for service coordination in accordance with the mechanism."[2]

System of Care Value: Transparent and Accessible

County FCFCs ensure that families and communities have information that allows them to make an informed decision about whether Service Coordination may be helpful and work to continuously eliminate barriers to engaging in Service Coordination.

> *Situation: Abigail Baker is the 20-year-old mother of 3-year-old Collin. Abigail is employed at the local plant and lives in her own apartment. Collin has been struggling in Pre-School and often gets upset during nap time. When upset, Collin will scream and cry until the pre-school calls Abigail. When she comes to pick him up, he calms down, goes home and naps. She has been asked to remove him from two other daycare/preschool options. The pre-school has indicated that they don't think they can keep him until they get some help. The Pre-School suggests she call the county FCFC. When she makes that call, she is welcomed by a Service Coordinator who sets an appointment for an initial meeting at the pre-school to begin talking about how resources can be pulled together to help this young family.*

County FCFC Responsibilities and Considerations

County FCFCs should identify clear pathways for families to access Service Coordination by identifying natural spots for a family to discover the option for Service Coordination. County FCFCs should review their process to make sure it's streamlined and easily navigated. All referral processes should minimally include:

- The date of the receipt of the referral;
- Contact information for the youth being referred;
  - Birthdate
  - Social Security Number
  - Gender
  - Ethnicity
  - Race
  - Address
- A brief description of the problems being experienced;
- Systems/agencies that have been involved with the person to date;
- Contact information for the person referring;
- Identification of Medicaid Managed Care Plan, if applicable;
- FCFC response to the referral or the outcome of the referral.

County FCFCs should evaluate their referral process to ensure that families can access Service Coordination, that information is shared in a way that is relevant and anchored to

[2] https://codes.ohio.gov/ohio-revised-code/section-121.37

families and that the process creates a “no wrong door” option for families seeking help. While not all the families who access the county FCFC will end up participating in Service Coordination, each family should know how to access the county FCFC and the outcome of their referral.

Welcoming and Engaging Families within County FCFC Service Coordination

Rules:

ORC 121.37(D)(3) Each county shall develop a family service coordination plan that "Ensures that assistance and services to be provided are responsive to the strengths and needs of the family, as well as the family's culture, race, and ethnic group, by allowing the family to offer information and suggestions and participate in decisions. Identified assistance and services shall be provided in the least restrictive environment possible."[3]

ORC 121.37(D)(6) Each county shall develop a family service coordination plan that "Includes a plan for dealing with short-term crisis situations and safety concerns."[4]

System of Care Value: Respectful

Families should feel respected and appreciated from their first contact with a Service Coordinator. Families should feel as if their story is welcomed and that their story matters throughout their entire relationship with Service Coordination.

> *Situation: 16-year-old Shawna is the youngest of three children and has attempted suicide 3 times in the last 6 months. She has one adult older sister, and one adult older brother. Parents, Jim and Nancy, contacted Family and Children First for help. A team is formed and meets weekly. After 3 months of service coordination, Shawna announces that she is gay, and that she is planning to go to prom with her girlfriend. Jim and Nancy share religious beliefs that conflict with this and have refused to accept that she is gay. Shawna begins to run away frequently and stops attending the team meetings because her parents are critical during the meetings. The Service Coordinator shares resources with her parents and counselor on LGBTQ+, as well as creates new rules for the team meetings on being respectful. The team begins to focus on Shawna's need to be accepted. They create more family bonding activities around Shawna's interests, such as cooking together. Shawna is also religious. The team searches for youth groups that may be more accepting of Shawna's preferences. The parents agree.*

County FCFC Responsibilities and Considerations

Service Coordinators are on the front line of communicating a sense of welcome for families. They take the value of respect and put it into practical application by setting up a series of trust-based interactions designed to build a sense of equal partnership. Service Coordinators take responsibility to ensure families feel welcomed. This is foundational to engagement. Rather than asking families to commit, Service Coordinators welcome each family in a way that reinforces their unique experience. There is no universal tool or technique that creates this sense of welcome. It is about the Service Coordinator always

[3] https://codes.ohio.gov/ohio-revised-code/section-121.373
[4] https://codes.ohio.gov/ohio-revised-code/section-121.373

remembering the family is a highly valued partner in this process and conveying that in all their interactions.

Additional Resources

- Implicit Bias Module Series
- Harvard Project Implicit

Assessing and Applying Strengths

Rule: ORC 121.37(C)(7) Each county service coordination mechanism shall include "A procedure for assessing the needs and strengths of any child or family that has been referred to the council for service coordination, including a child whose parent or custodian is voluntarily seeking services, and for ensuring that parents and custodians are afforded the opportunity to participate."[5]

System of Care Value: Honoring

Exploring and honoring the experiences of those participating in Service Coordination allows for a deeper understanding of what is important to the youth and families being served. In sharing their stories, families should feel affirmed, their knowledge valued, and their resilience recognized.

> *Situation: James is a 15-year-old male on the autism spectrum. He lives with his mother Jean and his grandfather Robert in his grandfather's home. James loves the feel of soil and will dig in his family's garden for hours when weather permits. He's also curious and regularly takes things apart to see how they work. At the initial team meeting, the Service Coordinator asked everyone to introduce themselves and share something about their relationship with James. When it was Grandfather Robert's turn, he shared how "exhausting" James can be. Not only does James regularly track dirt into the house from his gardening and leave disassembled parts for grandfather to repair, but when upset, James has increased strength and will remove every piece of furniture from his room to the living room, then sits in his bare room to quiet himself. Once calm, grandfather helps James move his furniture back to his room. One team member who was meeting the family for the first time listened to Robert and responded, "You are the most patient person I have ever met!" Hearing that, Robert's eyes welled up and he replied, "No one has ever said that to me before." It was evident that from such a simple, spontaneous comment, Robert felt affirmed, valued, and recognized. And it elicited from Jean additional stories of Robert's calm manner, generosity and kindness during the time she and James have lived with him.*

County FCFC Responsibilities and Considerations

In all interactions with families, Service Coordinators should convey their interest and privilege to be a part of the family's journey. Summarizing the family's story in a way that honors their experience has the potential to change how people view and interact with the family and inspire new possibilities for *Help* and *Healing*. Steps a Service Coordinator can take in the process of gathering, promoting, and utilizing strengths include:

- Set the stage for a friendly and respectful conversation with the youth and family members
    - Consider the right setting for both the parent and youth to be most comfortable

[5] https://codes.ohio.gov/ohio-revised-code/section-121.37

    - Make collaborative decisions with the parent and youth about when to meet and whether you should connect with the parent and youth together or separately
- Actively attend to the way that each family member tells their story
    - Use empathy to gather more information
    - Listen to how the story is told to understand what events mean to each member
- Formalize your understanding of the story through a narrative summary or timeline
    - Empowers others to better understand what is important to the family
    - Promotes empathy for what the family has experienced
- Summarize strengths and share with family and others involved in service coordination
    - Develop strength lists for each member of the family and for the family as a whole
        - Continuously update strength lists and make them available to everyone involved in the process
- Develop strength-based plans by selecting options that have the strongest tie to real strengths

Assessing and Addressing Needs

Rule: ORC 121.37(C)(7) Each county service coordination mechanism shall include ”A procedure for assessing the needs and strengths of any child or family that has been referred to the council for service coordination, including a child whose parent or custodian is voluntarily seeking services, and for ensuring that parents and custodians are afforded the opportunity to participate.”

System of Care Value: Responsive

When Service Coordinators focus on need, they can empower helpers to understand the “why” of a situation and adjust their response to the why. Service Coordinators should work to understand what is beneath a situation. Service Coordinators use this understanding to build bridges with community and service providers along with the family to come up with new ways to respond to the underlying causes. This creates a responsive versus reactive system.

> *Situation: The Service Coordinator receives a call from a school saying that they need help reaching a parent. The school says the parent is overprotective and is almost hostile to the school, accusing them of hurting her son who is in third grade. They think she could use some help. The Service Coordinator agrees to reach out to the mother, who says that her son, who has Autism, often has small scratches on his neck and scalp. She says she’s worried that other kids are bullying him, and the school isn’t protecting him. The mother and Service Coordinator agreed the Service Coordinator will drop in at school in the next few days. When the Service Coordinator arrives at the classroom, she notices that the young man sits near the window. While she is observing, a custodial staff starts mowing the lawn. At that time, the young man begins pulling at his ear and swatting at his head. The Service Coordinator mentions it to the teacher who says she’s never really noticed this behavior. The teacher and Service Coordinator call his mother and they decide to move his desk away from the window. The teacher and mother agree to connect early next week to follow up.*

County FCFC Responsibilities and Considerations

Needs are defined as the underlying reasons or cause of a situation. People communicate their needs in one of three ways.

- Most frequently, people communicate their need in their behavior. Unfortunately, if the behavior is seen as challenging, helpers may rush to manage the behavior rather than understand the need.
- People may communicate their need in the patterns of their behavior. When the need is embedded in their history, helpers may work to either keep the event from repeating or make assumptions about the person’s motivation.
- Least often needs are communicated verbally. People may communicate what they want but that’s not the same as talking about why it’s important. Additionally, individuals may communicate what they must or should do rather than talking about how it matters to them. When helpers hear a “want” or a “must” they will try to make something available without understanding the importance.

Developing a Specific Team for Each Family

Rules:

ORC 121.37(D)(2) Each county shall develop a family service coordination plan that "Designates an individual, approved by the family, to track progress of the family service coordination plan, schedule reviews as necessary, and facilitate the family service coordination meeting process."[6]

ORC 121.37(C)(6) Each county service coordination mechanism shall include "A procedure for protecting the confidentiality of all personal family information disclosed during service coordination meetings or contained in the comprehensive family service coordination plan."[7]

System of Care Value: Collaborative

Service Coordination doesn't happen in a vacuum. County FCFCs set the stage for families to have an experience of coming together in authentic partnership around the family's priorities. This doesn't mean that each family's story is an open book that is read out. Instead, the Service Coordinator works with the family to identify how to best build a team and strategically guides the process and shortens the wait from *Hello* to *Hope*.

> *Situation: Mike, 12, lives with his grandmother, Michelle. She works as a Clerk for the county and agreed to take in Mike last summer when things were getting tough at his home. He seems to do better in the quiet of her home as there are four younger siblings at his mom's home. She is happy to help and actually likes having him around but last month she was diagnosed with cancer and is worried about how he will do as she goes through treatment. Both she and her daughter, Michaela, agree that her home is the best place for Mike, but they have concerns about his supervision. The Service Coordinator works with Michelle, Michaela, and Mike to generate a team that will identify meaningful help for the family. Team members include Michelle, Mike, his aide at school, Michaela, Michelle's doctor's office and three of Michelle's friends from work. They begin a meeting by considering everyone's strengths and then put together a mission statement about keeping the household together. Everyone leaves the first meeting with a schedule to share the household care during each week of Michelle's treatment. This includes naming a Team Captain each week as well as a schedule to pick up Mike at school and for delivering meals.*

County FCFC Responsibilities and Considerations

When families are receiving lots of services, their biggest unmet need may often be loneliness. When youth, parents or caregivers feel like they're being served rather than being seen, they may feel invisible. When families feel like they're being interviewed rather than being understood, they can feel erased. County FCFCs set the table to bring individuals together with each family so that parents and youth feel that others are paying attention, their perspective is heard, and their input is valued. This doesn't mean that the

[6] https://codes.ohio.gov/ohio-revised-code/section-121.37
[7] https://codes.ohio.gov/ohio-revised-code/section-121.37

family's story is an open book, but instead the Service Coordinator works with the parent and youth to identify who and what resources may be helpful in moving the family to a sense of connection and hope. Building a team is a means to an end rather than the end itself. Good teams in Service Coordination will be:

- *Efficient:* Bringing resources together around the family rather than sending them out to seek it on their own
- *Individualized*: No two teams should be exactly alike. Team membership should be driven by the family's sense of identity, priority, and culture.
- *Comprehensive*: Each team should be reflective of a whole life rather than a single dimension of a family's life.
- *Effective:* Teams and team members should have the ability to blend strategies in the areas of services, support, and community membership.

Teams don't spontaneously come together. Service Coordinators should be prepared to build a team with the family and to guide the team. This requires bringing people together in the form of family focused team meetings; leading the team to collaboratively develop a future oriented direction; and summarizing those results in the form of an ongoing plan with various levels of crisis contingency. Over time, teams continue building a sense of community. Their collaboration can ensure strategies are effective, adjustments are made based on family input and preferences, and desired outcomes are achieved. **A team can do far more damage than any single individual, but a well-structured and supported team can produce so much more than one individual.** Service Coordinators work with the team, including the family, to co-create the plan. Finally, a Service Coordinator must strike the right balance between each family's right to privacy with a team's need for transparency.

Planning With the Family

Rules:

ORC 121.37(C)(3) Each county service coordination mechanism shall include "A procedure that permits a family to initiate a meeting to develop or review the family's service coordination plan and allows the family to invite a family advocate, mentor, or support person of the family's choice to participate in any such meeting."[8]

ORC 121.37(C)(8) Each county service coordination mechanism shall include "A procedure for development of an individual family service coordination plan."[9]

ORC 121.37(D)(3) Each county shall develop a family service coordination plan that "Ensures that assistance and services to be provided are responsive to the strengths and needs of the family, as well as the family's culture, race, and ethnic group, by allowing the family to offer information and suggestions and participate in decisions. Identified assistance and services shall be provided in the least restrictive environment possible."[10]

System of Care Value: Partnering

Service Coordination is not something that is simply given to a family but instead is a set of purposeful activities that are done with a family.

> *Situation: Lori and her daughter Ruth, 15, have participated in a range of system services for years. At times, it seemed like the family found the services provided helpful. Unfortunately, that sense of progress is usually short lived, and Ruth begins to refuse to attend. When this occurs, Lori feels pressured to get Ruth to participate. Lori felt fed up and left a message on Ruth's PO's voice mail that said, "I've had enough, and I'm just done. You keep telling me to do this and that, but you don't hold her accountable. I won't kick her out but I'm not fighting this anymore. If you want to contact her, don't go through me." This call caused the PO to make the referral to the county FCFC. The Service Coordinator reached out to the family by starting with Lori. During that initial call, the Service Coordinator indicated that the process would involve meeting over time with Lori, Ruth, and others but throughout the process they would meet to check in with how the family is feeling about how things are working. Lori continues to be reluctant about getting involved with another process that will tell her what to do until the Service Coordinator says "Lori, we're not here to tell you what to do. Instead, what we do with Service Coordination is asking you and Ruth what you need and then try to address it. When we check in, we're going to ask you if it's working and here at the Service Coordination table, we won't blame you if you change your mind." Lori takes a deep breath and agrees to try it but only for a couple of months. Ruth says that this sounds different and if it keeps her mom from getting more frustrated, she's all for it.*

[8] https://codes.ohio.gov/ohio-revised-code/section-121.37
[9] https://codes.ohio.gov/ohio-revised-code/section-121.37
[10] https://codes.ohio.gov/ohio-revised-code/section-121.37

County FCFC Responsibilities and Considerations

Service Coordination requires bringing a group of people together around a common sense of the family's strength to focus on those needs prioritized by the family to develop a comprehensive plan. Planning is an action rather than a thing. The first plan represents a team's best first efforts and all families deserve to know they are working with Service Coordinators and teams that are appreciative of their unique identity and that are empowered to keep trying new things until the last thing becomes the best thing. Service Coordinators may focus on the following when developing a process for planning with a family:

- Ensure families understand the process. Find ways to communicate your process including ensuring that families have access to other families who have gone through the process.
- Prepare for team meetings.
    - Get to know the family and other team members before the meeting. Identify what is likely to make the process work for each family.
    - Prepare team members with information about what is expected in the meeting. This includes the family and other community/system members who will be participating. Everyone deserves to be oriented. This promotes cohesion and sets the stage for understanding.
    - Structure your agenda with the family in mind. Service Coordinators should use a standard agenda as a starting point and outline but be prepared to tailor it to the individual needs and unique identity of the family.
    - Create a sense of welcome and appreciation at each encounter. Return to the family's strengths at each encounter and remind others to do the same.
- Review your plans to make sure the goals are realistic and attainable.
    - Review your plans at least quarterly. If all your plans use the same resource, it's highly likely that your coordination process fits families to it rather than tailoring the process to families.
    - Challenge your teams to be creative and individualize. Challenge yourself and teams to consider the fact there is no "one size fits all" when it comes to families. Use the axiom that "one size fits one."

Develop a Crisis Response/Safety Plan

Rules:

ORC 121.37(D)(4) "Each county shall develop a family service coordination plan that "Includes a process for dealing with a youth who is alleged to be an unruly child. The process shall include methods to divert the child away from the juvenile court system."[11]

ORC 121.37(D)(6) Each county shall develop a family service coordination plan that "Includes a plan for dealing with short-term crisis situations and safety concerns."[12]

System of Care Value: Promoting Safety

Families define their own crisis. Communities set the stage for managing safety. There is a difference between a crisis and a safety situation. Service Coordination involves maximizing protective capacity on a personal, system and community level.

> *Situation: Tricia and her daughter Meredith, 15, were referred to the county FCFC for Service Coordination. They have been receiving services from the Behavioral Health system for the past two years after Child Welfare received a referral because two of them were living in a hotel and possibly were going to be unhoused. Child Welfare didn't open a case since Tricia was always able to make sure Meredith was safe. They were concerned about how closely entwined the two of them were and referred them to the Mental Health Center for services. They have received therapy and Community Support Services. During this time, the Community Support Specialist has worked with them to access stable housing. Most recently they were set to move into a subsidized housing unit and, at the last minute, Tricia indicated that they might have to leave town to go see her mother (Meredith's Grandmother) because she is ill. The Community Support Specialist is frustrated and keeps referring to the fact that the family isn't safe due to housing instability. The Service Coordinator takes the referral and sorts through the risk situations that present a specific danger to the family. Finding there is minimal danger, the Service Coordinator goes on to meet with Tricia and Meredith to sort through what worries them and what they perceive as dangerous. She discovers that these two don't really experience housing instability as a crisis as they always know where to go to make sure they are warm, well-fed, and okay. They indicate their biggest worry is that they will get separated. The Service Coordinator works with them about what to do if that should happen and what steps to take to keep it from happening. The Service Coordinator gets together with the Community Support Specialist, Meredith, and Tricia to address those items and everyone agrees to work on making sure the family doesn't have to experience those things that represent a crisis for them. Additionally, the Community Support Specialist is supported to explain her worry about safety and what steps she will take if things start to present a risk. They agree to move forward with this understanding.*

[11] https://codes.ohio.gov/ohio-revised-code/section-121.37
[12] https://codes.ohio.gov/ohio-revised-code/section-121.37

County FCFC Responsibilities and Considerations

County FCFCs should identify a process to ensure that all family members are safe and to help system partners understand the difference between crisis and safety. This is not just about filling out a form but ensuring that two things happen. The first is that all family members should have confidence that others work to ensure that they're safe. The second is that Service Coordinators will help family members define their own crisis and work with them so they can manage that crisis.

Service Coordinators should be prepared to differentiate between a crisis situation and safety situation. Service Coordinators have options and time when dealing with a crisis situation. This protocol outlines the crisis response. In situations where there is a risk of harm or danger, Service Coordinators should have a range of resources for immediate response. In those high risk or threat circumstances, Service Coordinators should follow a clear logic that begins with asking people what happened. As quickly as possible, a Service Coordinator should ask whether a person is safe. If the answer is "Yes" then the immediate risk is low and the process outlined below can be followed. If the answer is "No", a Service Coordinator should follow up with how soon will someone be harmed?

If the answer is immediately (an hour or less, typically), the Service Coordinator should link to the right community resource designed to help citizens be safe. If the answer is soon (usually under two hours), the Service Coordinator should tailor access to the resource in a way that reflects the family's wishes. Finally, if the answer is later the Service Coordinator can follow the process listed below to gather more information. While this process is outlined in the *Hello* stage, this logic should be applied throughout the process of working with a family to ensure that families who are experiencing a high threat or danger get access to the right resource in the right way at the right time.

A Service Coordinator will address Crisis and/or Safety in different ways as they work with a family over time. In building this capacity, Service Coordinators should identify the tools and techniques that will promote a sense of safety and allow families to define their own sense of crisis throughout the service coordination process. In developing those capacities consider the following stages of the Service Coordination Process:

- At Intake and Initial Connection (The *Hello* Stage)
    - Service Coordinators should always check with the youth and caregiver to identify any areas of risk or threat. This involves a dialogue with the parent/youth about what they see as risk as well as checking with the original referring partner. This will involve sorting those risky situations on two levels:
        - Immediacy: This involves determining what is likely to happen and when. This is done so the Service Coordinator can gauge how quickly they must act
        - Impact: This involves how dangerous the risk and how many will be impacted. This produces a sense of how much the Service Coordinator must put in place to ensure a minimal amount of safety.

- Service Coordinators should recognize that these initial responses are meant to produce a sense of enough stability to begin a robust process of Service Coordination. Things that are put in place may be put in place temporarily. If the timing is very short, the Service Coordinator should begin planning and implementing faster rather than waiting for risk or stabilization issues to be resolved before the planning process begins. When there is a risk or crisis, Service Coordinators should plan faster.

- During Initial Plan Development (The Help Stage)
  - As the Service Coordinator moves from initial safety promotion, they move to a planning approach focused on the family's sense of hope and future. This is the stage where the underlying causes (unmet needs) will begin to be articulated and addressed throughout the process. This involves identifying protective capacities of family members as well as protective capacities in the community to develop an ongoing set of coping strategies that minimize danger.
  - Service Coordinators continue to sort crisis and safety situations during this stage. In crisis situations, they work to implement wellness promotion activities to help families be able to manage crisis while practicing recovery techniques. This may involve a set of tools that promote self-care techniques, working on building alternative habits or ensuring access to people, places, and things the family is likely to find helpful during crisis. The Service Coordinator also works with the family and team to continue to reinforce the fact that some families choose to live more in crisis than others and as long as the line into unsafe isn't crossed, crisis may occur without system intervention.

- During Plan Implementation (The *Healing* Stage)

  Over time the Service Coordinator works with the family and team to ensure that risk situations are minimized and well managed. The Service Coordinator keeps track of data about frequency, duration, and intensity of events and summarizes that for the family and team to review. Families and team members adjust based on data. This is also a time when a series of safety rehearsals may occur that allow the family to try on new pathways for managing risk as well as informing team members what works and what doesn't. This process occurs for both crisis and safety circumstances.

- As Service Coordination Comes to a Close (The *Hope* Stage)

  The Service Coordinator works with the family and team to project a future without a formal service coordination process. This will involve implementing some unplanned risk and crisis drills that allow the family to test their response. It also asks the family and team to project their worries about both crisis and safety and build a set of resources the family can access if needed. This may involve making personal introductions to community resources, providing families with letters for future emergency responders as well as establishing a wellness calendar that families can use as a reminder to use the tools that have been developed throughout the process.

FCFC Crisis Form Template

Youth Name:	**Youth Identification:**	**Family/Caregivers Names:**
Emergency Contact Name/Role (*physician/therapist*):		**Phone:**
Date Initial Document Completed:	**Youth Signature:**	**Parent/Caregiver Signature:**
Revision Dates: ❑ _____ ❑ _____ ❑ _____	**Revision Dates Initials:** Parent _____ Youth _____ SC _____ Parent _____ Youth _____ SC _____ Parent _____ Youth _____ SC _____	

Household Medication	
Youth's Current Medications *List all Medications/Dosage/Frequency*	*Other Medications in Household that could present safety concerns. List who/dosage/frequency*
1.	**1.**
2.	**2.**
3.	**3.**

Crisis Concerns			
Youth's Diagnoses *List all diagnoses*	*Special Health Concerns* *List all in the Household*	*Risks in the Neighborhood or Home*	*Other* *Please List Here*
1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**
Family Member Name & Role *Parent, Youth, Sibling, Other*	**What Does Each Family Member Identify as a Crisis?** *What Does the event look & feel like to those involved?*		

Potential Crisis Event	**What Conditions Lead to a Crisis?** *Consider physiological, environmental and emotional*

Potential Crisis Event	**Describe What Happens During the Crisis Event** *Include warning signs, successful strategies used in the past, strategies to avoid.*

Proactive Prevention Plan *Who & what actions and/or supportive services are helpful in averting a crisis?*		
Potential Crisis Event	**Agreed-Upon Actions** *Specify steps to be taken to avert a crisis*	**Who Is Responsible?** *Contact Information*
Potential Crisis Event	**Agreed-Upon Actions** *Specify steps to be taken to avert a crisis*	**Who Is Responsible?** *Contact Information*

Reactive Response Plan *What steps are to be taken/not taken to resolve the crisis?*		
Potential Crisis Event	**Action Steps** *Specify steps in implementing the plan; identify supports & services that may need to be accessed*	**Who Is Responsible?** *Contact Information*
Potential Crisis Event	**Action Steps** *Specify steps in implementing the plan; identify supports & services that may need to be accessed*	**Who Is Responsible?** *Contact Information*

What follow-up actions are to be taken following a crisis?

Service Coordination Safety Information Template

Youth Name:	**Parent/Caregiver Name(s):**	**Lead Agency:**
Phone Number(s):	**Address:**	
Date Initial Document Completed:	**Youth Signature**	**Parent/Caregiver Signature**

Revision Dates:	**Revision Dates Initials:**
❑ _____	**Parent** _____ **Youth** _____ **SC** _____
❑ _____	**Parent** _____ **Youth** _____ **SC** _____
❑ _____	**Parent** _____ **Youth** _____ **SC** _____

Special Household Member Safety Situations

Please list all household members and any safety concerns. Enter the medication dosage and type. Also mark medications throughout the family that could present a safety concern.

Name	Age	Medications	Special Health Concerns

Physical Plant Safety Conditions

Review the physical layout with the family and identify any areas of concern that might present a risk within or outside of the home.

Areas to consider	Areas	Specific Concerns
Consider utilities, windows, tools, windows, traffic when discussing risk areas.	Living Room	
	Kitchen	
	Bedrooms	
	Garage	
	Neighborhood	
	Other	

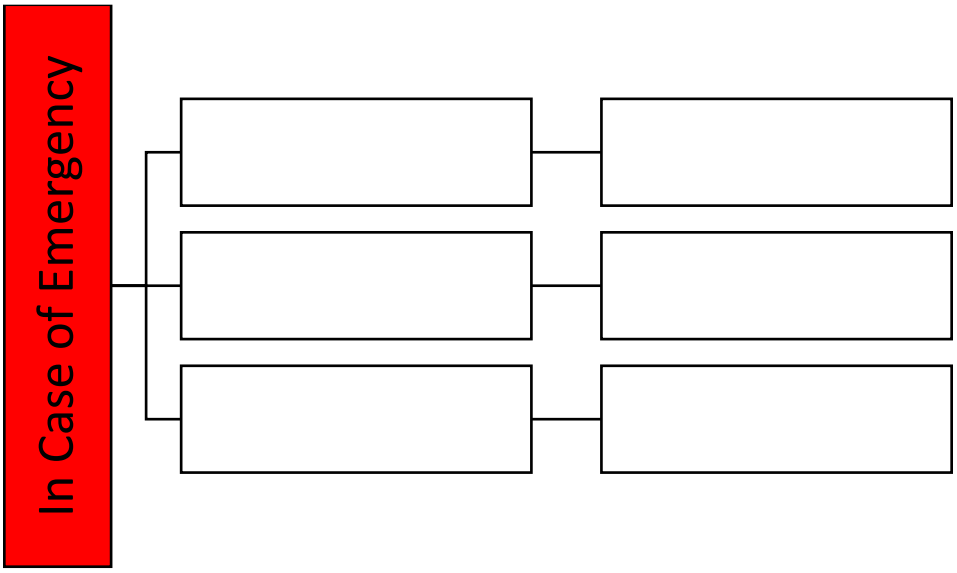
Safety Concerns List the top three risk areas from the above conversation and identify on a scale from 1 (least) to 5 (most) how each person sees the risk.	**Risk Scaling**		
	Youth	**Parent**	**Service Coordinator**
1.			
2.			
3.			

Contact and Response Form

Use this page to brainstorm the range of people or places who can be contacted. Once the planning process starts, a range of options will be identified. At the bottom of the page identify the top contact numbers to call to get help in order from first to last.
Send this page with the family when it is completed.

Emergency Responders and Supports All emergency resources and numbers should be listed here.			
Community Resources	**Contact Number(s)**	**Youth and Family System Resources**	**Contact Number**
Police Department:		**Lead Responder:**	
Fire Department:		**Service Coordinator**	
Poison Control:		**Mental Health:**	
Emergency Room:		**School:**	
Crisis Helpline:		**Child Welfare:**	
Other(s):		**Juvenile Justice:**	
		Others(s):	
Friends, Family and Connections			
Name	**Contact Number(s)**	**Role and Commitment**	

Initial Safety Response



Measuring for Outcomes

Rule: ORC 121.37(D)(5) Each county shall develop a family service coordination plan that "Includes timelines for completion of goals specified in the plan with regular reviews scheduled to monitor progress toward those goals."[13]

System of Care Value: Adaptable

Expectancy is defined as "the state of thinking or hoping that something, especially something pleasant will happen or be the case." Families deserve expectancy throughout their participation in Service Coordination. That expectancy is not only about holding ourselves accountable for follow-through and results but should also focus on the fact that Service Coordination will involve adjusting services and resources based on whether they are producing results or not.

> *Situation: Maureen and her son Ben, 13, have recently started participating in Service Coordination through the county FCFC. Ben and Maureen started therapy about a year ago after Ben's dad died suddenly in an accident. Maureen reports that Ben has become more argumentative and combative during this time. Maureen has persevered and continued to get Ben to see the therapist. The Service Coordinator asks the therapist, Ben's informal Probation Officer and the school counselor to get together. Ben's paternal Aunt from another state calls in. During this meeting, everyone agrees that therapy sessions should increase and include Maureen. After six weeks, the Service Coordinator checks with Maureen who indicates that she and Ben are fighting a lot on the way to family therapy. Maureen indicates that while she knows better, she keeps avoiding the conflict. As a result, Maureen and Ben keep showing up late to therapy. Maureen goes on to say that while she wishes it would work, it doesn't feel like it's helping. The Service Coordinator facilitates a discussion between Maureen, Ben, and the Therapist where they explore some options. During that discussion, the Therapist suggests they meet twice monthly for twice as long rather than weekly. They all agree to try it for two months. During that time the Service Coordinator agrees to keep track of whether they get to appointments on time, whether arguments happen less often and whether Ben and Maureen report that they feel better. This is an example of adapting response based on Outcome.*

County FCFC Responsibilities and Considerations

Service Coordinators track three levels of response in pursuing an outcome-based approach. The first is *follow-through* that begins with Service Coordinators following through with promises they make and actions they take in reaching agreement with families. The second component is about a *fact-based approach* which details results or outcomes in behavioral terms. These outcomes should be easily countable and clearly defined so that all members of the team can see progress as it occurs. The third level is *feeling-based* and involves the parent and youth reporting that they feel that things are getting better.

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[13] https://codes.ohio.gov/ohio-revised-code/section-121.37

Service Coordinators summarize all three levels throughout the process and use this information to adjust and adapt services and supports. Tips for all three levels include:

- **Follow-Through**
  - Track follow-through for all team members rather than focusing on a single team member such as a parent or youth
  - Positively note when any team member follows through, even when people start a job rather than finish it, recognize the accomplishment
  - If follow-through is a challenge, find ways to bring different team members together to work on task completion
  - Provide an overview of team progress on follow-through to build a sense of accomplishment among all team members
- **Fact-Based**
  - Pick behavioral counts that are relevant to what brought the family in
  - Build targets for what you want to see in terms of behavior rather than what you want to stop
  - It's often easier to count the challenge but always report on the positive, such as the number of days a youth attended school.
  - Reward progress along the way. It is likely to take time to reach the ultimate target.
- **Feeling-Based**
  - Find a way to discuss the family's sense of well-being. This may be asking the parent/caregiver or youth if they feel more confident or whether they feel that needs are met.
  - Recognize that you can have strong outcomes but if people don't feel better things are unlikely to actually become better
  - Check for the family's sense of confidence or well-being throughout the process. If you don't see progress, make changes to your approach.

As Service Coordinators work through this process with families, team members and communities, an outcome focus creates a dashboard for data driven decision making. Identifying and measuring outcome as an ongoing part of Service Coordination sets the stage for Service Coordinators to work with families about their expectancy while holding themselves and team members accountable. An outcome focus allows everyone to work smarter and ensures families get the right response in the right time to produce the right results.

Adjusting Response to Family Transitions

Rule: ORC 121.37(C)(5) Each county service coordination mechanism shall include "A procedure for monitoring the progress and tracking the outcomes of each service coordination plan requested in the county including monitoring and tracking children in out-of-home placements to ensure continued progress, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment, and education."[14]

System of Care Value: Family-Focused

Transition means things are changing. Families are always in some state of transition. For youth and families involved in Service Coordination, the intent is that things change for the better and that over time families experience a sense of growth and hope for the future. If Service Coordinators can understand enough in the *Hello* component to deliver help in the shortest amount of time while joining with the family in reviewing and improving help, then *Hope* will blossom. In essence, *Hope* happens when *Healing Help* is provided.

> *Situation: Catherine, 17, was placed in a therapeutic foster home following several suicide attempts that resulted in repeated psychiatric hospitalizations. The foster home was in a rural community about 30 miles south of the apartment Catherine shared with her mother Marjorie in an urban area. Traditional weekend visits to prepare for Catherine's return home were not doable because Marjorie was employed as a nurse and was routinely scheduled to work weekends. Catherine's Children's Services worker made the referral to Service Coordination for support in developing a plan that would bring Catherine safely home. The Service Coordinator, Susan, met with Catherine, Marjorie and the foster parents Stacy and Mike to welcome them all to Service Coordination and to hear their story. During that conversation Catherine talked about her time at the hospital and how much she enjoyed the art projects there. She also shared that she was most nervous about returning to her large metropolitan high school. Marjorie was worried about the amount of time Catherine would be on her own while she was at work and hoped they could figure out some things for her to do. Stacy and Mike talked about the progress Catherine has made during the six months she has been with them and mentioned how helpful she is, routinely helping out at the bike shop they own and at their friend's stable. Hearing their story provided direction and the Service Coordinator suggested pulling in a representative from the school ASAP. All agreed and within a week they held a meeting with the school's special education director to discuss alternative education options. The district had a contract with a small alternative school that served only high school students with "internalizing behaviors." Catherine, Marjorie, and Susan visited the school and thought it would be a good fit. With a school placement secured, a team and plan were developed. The plan included a "reverse foster care" arrangement that had a neighbor of Stacy's who worked near the new school driving Catherine in on Monday mornings and returning her to the foster home Friday after work. During the week Catherine went home from school daily and spent time with her mom. With the help of the team, they located a*

[14] https://codes.ohio.gov/ohio-revised-code/section-121.37

community center with a strong arts program. They identified weekend volunteer opportunities that Catherine was interested in and planned to work with the vocational counselor at the school to prepare her for part-time employment on the weekends. The formal team stayed involved for several months after Catherine went home "full time." As it became apparent that the support of a formal team was no longer needed, the team discussed Catherine and Marjorie's accomplishments. They identified who would stay involved, both the formal services and the informal personal and community supports. Healing help had led Catherine, Marjorie, and the entire team to a place of hope.

County FCFC Responsibilities and Considerations

In Service Coordination, transition often refers to the time when a family has made significant progress and is ready to manage future challenges without the support of a formal team. But just as *Hello* isn't something that only happens at the outset of the arc of care, *Hope* isn't confined to the closing moments. *Hello* should kindle and nurture *Hope* throughout the course of the process. *Help* should be delivered in the context of a powerful optimism designed to increase expectancy on the part of all team members, including families. *Healing* should be recognized throughout the entire Service Coordination process to acknowledge and celebrate gains and set the stage for a future of possibilities.

- From their very first contacts with a youth and family, the Service Coordinator should be focused on taking purposeful action to ensure a family has the help necessary for continued success.
- Throughout the process, the Service Coordinator should look for and summarize positive changes in the youth and family's ability to manage challenges and access necessary support.
- Service Coordinators should work to customize services and resources to the family and prepare to adjust those resources based on a family's ongoing transition.
- As a family gets closer to moving out of formal service coordination, the Service Coordinator, should guide the team in preparing a detailed strengths-based transition plan to support the youth and family when new challenges happen. The transition plan should include:
    - A brief summary of what brought the youth and family to Service Coordination, what they worked on and where they are now.
    - Youth and family accomplishments including skills developed, positive changes made, successes celebrated, and anything else the family wants to include.
    - Strengths of family members and the family as a whole.
    - Steps for diffusing or managing potential family identified crises situations.
    - Contact information for persons the family can turn to for support and the kinds of help they can provide.
    - Contact information for service providers who will be staying involved with the family.

- A list of community resources the family can access to meet family identified future needs.

Planning with Youth, Families and Congregate Care

Rules:

ORC 121.37(C)(5) Each county service coordination mechanism shall include "A procedure for monitoring the progress and tracking the outcomes of each service coordination plan requested in the county including monitoring and tracking children in out-of-home placements to ensure continued progress, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment, and education"[15]

ORC 121.37(D)(3) Each county shall develop a family service coordination plan that "Ensures that assistance and services to be provided are responsive to the strengths and needs of the family, as well as the family's culture, race, and ethnic group, by allowing the family to offer information and suggestions and participate in decisions. Identified assistance and services shall be provided in the least restrictive environment possible."[16]

System of Care Value: Ongoing

When circumstances result in a youth being placed in out-of-home care it's imperative that helpers recognize the importance of ongoing involvement with the youth and family, and in those instances when a custodial agency is involved, a representative from that agency. Service Coordinators recognize that this is more than a single event and should be prepared to work with families regardless of the service environment. From the moment of referral until the youth returns to their family and community, the focus should be on creating the conditions for ongoing, long-term stability and success.

> *Situation: Tyrone is 14 years old. He lives with his mother Latecia and 6-year-old brother Gregory in the upstairs of a two-family home. The home's owner Andre lives downstairs with his family. Tyrone has been involved with the Board of Developmental Disabilities since he was a young child and Latecia has a good relationship with the Service and Support Administrator (SSA) Dave. Recently Tyrone had an outburst and threw a television through the window. When Latecia was unable to calm him, Andre called the police who took him to the hospital. The hospital social worker felt the home situation was unsafe and called child protective services (CPS). CPS sought emergency temporary custody and at the hearing Latecia made it clear she did not want Tyrone taken from her. The judge recommended he be placed in a residential center for evaluation before she made a determination about custody and assigned an investigative probation officer (PO). With so many professionals now involved, the SSA Dave recommended Service Coordination. Latecia had previous involvement with Service Coordination and was agreeable to the referral. The Service Coordinator quickly worked with Latecia to bring together the professionals to figure out exactly what was to be evaluated during the residential stay. They began ongoing weekly meetings to ensure the treatment staff was meeting their expectations about what they wanted addressed while Tyrone was at the center.*

[15] https://codes.ohio.gov/ohio-revised-code/section-121.37
[16] https://codes.ohio.gov/ohio-revised-code/section-121.37

Additionally, the Service Coordinator and Latecia used the time Tyrone was in placement to build a family focused team that, along with the professionals, included the homeowner Andre, several relatives, Tyrone's father James, and a respite provider Ed whose services were funded by DD. As a team they began planning for Tyrone's return home with emphasis on safety. At one point Latecia wanted to remove Tyrone from the center. The PO explained that Latecia could do that since she is the parent and has custody, but that it was very likely the judge would view that as a safety risk and order CPS to take custody. She also assured Latecia that with all that she has been doing to care for her two sons and her openness to additional forms of help, she would advocate with the judge that Tyrone be returned home. Reluctantly, Latecia chose to continue placement as she did not want to risk losing custody. As the hearing approached, the team wrote a letter, signed by every member, stating why Tyrone should return home, outlining the plan for ongoing supports and services and emphasizing the contingencies included to ensure ongoing safety. Additionally, as many team members as were able attended the hearing to demonstrate their support for Tyrone's return to Latecia and to answer any questions the judge might have about their ongoing involvement.

County FCFC Responsibilities and Considerations

When a youth is referred for congregate care, the Service Coordinator should consider both long and short-term objectives, as congregate care is only one step in an ongoing process. Being clear about the long-term plan allows the Service Coordinator to guide the team in identifying what is expected while a youth is in care that will allow for their safe return to family and community. Ongoing planning before, during and after placement sets the stage for long term stability and success. Steps that a Service Coordinator and family team can take during the time a youth is in congregate care include:

1. Before or as soon as possible upon placement the service coordinator should:
    - Identify with the family, and in those instances when a custodial agency is involved, a representative from that agency, and other team members with concerns they want addressed/treated during the congregate care stay
    - Clarify with the team how progress will be evaluated
    - Ensure that providers are clear about treatment expectations
    - **Remind the team that they will need to meet more frequently during the youth's stay in placement to monitor for results**

2. Throughout the time the youth is in care, the team should monitor progress in treatment by:
    - Holding regularly scheduled, preferably weekly, progress monitoring meetings that include congregate care staff as temporary team members
    - Ensuring congregate care goals align with family team goals
    - Monitoring progress toward achievement of identified goals
    - Where progress is not occurring, the team should consider the reasons and ensure the center is making necessary adjustments to shift progress

3. Ongoing, the Service Coordinator should guide the team to identify the steps necessary to prepare the youth and family for the youth's return to family and community and, as appropriate, facilitate the process to ensure the family is not overwhelmed. Those steps should include:
    - Ensuring the youth has positive connections in the community based on their strengths, interests, and culture by identifying and, whenever possible, continuing or introducing new connections (e.g., peer support, youth programs) while the youth is still at the center
    - Determining what services and supports, both formal and informal, will be needed for the youth's successful return to the community, making linkages to initiate services while the youth is still at the center and considering barriers (e.g., funding, transportation) and strategies to overcome those barriers
    - Identifying with the family what they need to support family connectedness while the youth is in congregate care
    - As soon as possible while balancing safety and attachment concerns, scheduling community and home visits to prepare family, youth, siblings, other caregivers, and household members for the youth's return
    - Identifying opportunities that exist or can be created for the family to practice new skills learned while the youth is in placement
    - Determining what additional support (e.g., respite, mentoring) the youth and family need for ongoing success
    - Identifying and preparing the youth and the school for the youth's return including enrolling, determining needed accommodations, and creating personal connections prior to the youth's return

Ongoing planning results in a strengths-based plan for the youth's return that takes into consideration: promoting safety; rebuilding relationships; developing reasonable expectations; predicting and problem-solving potential challenges and needs. It requires the team continue their commitment to working with the family and supporting them in their healing journey toward long term stability, success, and hope.

Service Coordination & High-Fidelity Wraparound Crosswalk

Organized by the Ohio Revised Code (O.R.C.) Service Coordination Components

The descriptions below are summaries of the county FCFC Service Coordination and High-Fidelity Wraparound Processes, organized by the Service Coordination Components outlined in section 121.37 of the Ohio Revised Code (O.R.C.). While both Service Coordination and High-Fidelity Wraparound are acceptable and meet O.R.C requirements; this document helps to compare and contrast the two processes. This tool can be used to help determine which process is most appropriate to use with specific families. Some councils may also use a blend of these two processes.

O.R.C. 121.37 (C)(1): A procedure for an agency, including a juvenile court, or a family voluntarily seeking service coordination, to refer the child and family to the county council for service coordination in accordance with the county service coordination mechanism.

	Service Coordination	High-Fidelity Wraparound
Referral Procedure	Family and Children First Councils should develop clear pathways for families to access Service Coordination or Wraparound Facilitation. Councils should embrace a "no wrong door" approach that is streamlined and easily navigated. The information below can help in determining whether a family should be directed toward traditional Service Coordination or High-Fidelity Wraparound.	
Intent	The intent of Service Coordination is to use, organize, and adapt existing community-based services and resources to help meet the needs of youth and families. Teams are tasked with the following: • Formatting the *alignment* of services provided • Ordering the *sequence* of services provided • Eliminating the *duplication* of services provided • Monitoring the *intensity* of services provided	The intent of High-Fidelity Wraparound is to organize and develop new, highly individualized supports and interventions to meet the underlying, unmet needs of youth and families. Overarching goals of this process are to: • Change the way people look at the family • Change the way people look at the problem. • Change what help may look like for the family

Target Population	Youth (aged 0-21) and their families who have needs in multiple county/government systems, who could benefit from a coordinated team-based planning process.	Youth (aged 0-21) and their families who have a complex set of needs that are not able to be met through the community's current array of services. Oftentimes Wraparound is reserved for youth who are not responding to traditional service approaches and/or are at risk of out-of-home placement. *"When you don't know what to do, do Wraparound."*

O.R.C. 121.37 (C)(2): A procedure ensuring that a family and all appropriate staff from involved agencies, including a representative from the appropriate school district, are notified of, and invited to participate in all family service coordination plan meetings.		
	Service Coordination	**High-Fidelity Wraparound**
Team Identification and Membership	The Service Coordinator, in collaboration with the family, will invite team members to participate in the planning process. Typically, the team consists of the family and current service providers. If the youth has educational needs, a representative from the school should also be invited. Families are also encouraged to invite natural supports.	Wraparound Facilitator will partner with the family to identify a child and family team. Individuals are chosen and agreed upon by family and youth to help meet their identified unmet needs. As needs are met and new needs are selected, team membership may change. Team membership should be driven by the family's sense of identity, priority, and culture. Team members should include natural and community-based supports and should include individuals who can help the team change the way people look at the family, change the way people look at the problem, and change what help may look like for a family. At least 50% of the Wraparound team should consist of people who are not being paid to be there.

O.R.C. 121.37 (C)(3): A procedure that permits a family to initiate a meeting to develop or review the family's service coordination plan and allows the family to invite a family advocate, mentor, or support person of the family's choice to participate in any such meeting.		
	Service Coordination	**High-Fidelity Wraparound**
Team Meetings	Team meetings take place at the agreed upon frequency and consistency of the team and family. Families are encouraged to initiate meetings as needed and invite individuals of their choosing.	Team meetings take place on a consistent basis throughout the entire Wraparound process. Traditionally, meetings are more frequent at the beginning of the process, less frequent in the middle, and become more frequent again towards the end. Due to the complexity of needs, Wraparound teams may meet more often and for a longer duration than Service Coordination teams.

O.R.C. 121.37(C)(4): A procedure for ensuring that a family service coordination plan meeting is conducted before a non-emergency out-of-home placement for all multi-need children, or within ten days of a placement for emergency placements of multi-need children. The family service coordination plan shall outline how the county council members will jointly pay for services, where applicable, and provide services in the least restrictive environment.		
	Service Coordination	**High-Fidelity Wraparound**
Placement Considerations	The Service Coordination process strives to keep youth in communities and with their families whenever possible. The team works to use, organize, and adapt the existing services and supports to achieve this goal.	The High-Fidelity Wraparound process strives to keep youth in communities and with their families whenever possible. The team works to create new, highly individualized interventions and supports, that focus on the entire family unit.
	If youth is placed in an out-of-home placement, team works with placement setting to maintain and strengthen community and family connections during the placement. Team will also immediately begin work with the placement setting to prepare the family and community for the youth's reunification and return to the community. Placement is considered a short-term intervention, not a long-term solution. Teams should continue to meet during the youth's out-of-home placement, to plan for what's next. It is advisable for teams to meet at a higher frequency during the youth's placement. Ongoing planning before, during and after out-of-home placement sets the stage for long-term stability and success.	

O.R.C. 121.37(C)(5): A procedure for monitoring the progress and tracking the outcomes of each service coordination plan requested in the county, including monitoring and tracking children in out-of-home placements to ensure continued progress, appropriateness of placement, and continuity of care after discharge from placement with appropriate arrangements for housing, treatment, and education.		
	Service Coordination	**High-Fidelity Wraparound**
Progress Monitoring and Outcomes Tracking	Service Coordination process includes procedures for tracking progress and developing timelines for completion of goals. Team schedules regular reviews to monitor progress toward those goals.	Progress is monitored through the development of benchmarks and feedback from the family and team. Team ties the needs and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.
	Teams should set up a system for tracking whether the supports and services are producing the desired results and then adjusting services and supports accordingly. Monitoring progress throughout the process can help the team recognize when the wrong needs have been prioritized or strategies in a plan aren't working and need to be amended. Progress monitoring helps the team determine the effectiveness of created interventions and supports and know if these supports are "working" to meet the needs of the youth and family. Service Coordinators/Wraparound Facilitators should be ensuring that team members are following through with commitments, and that the family and youth feel that things are getting better. Outcomes should be easily countable, measurable and clearly defined so that all members of the team can recognize progress as it occurs. Data and information on progress can help highlight when a family is ready to transition out of Service Coordination or High-Fidelity Wraparound.	

O.R.C. 121.37(C)(6): A procedure for protecting the confidentiality of all personal family information disclosed during service coordination meetings or contained in the comprehensive family service coordination plan.		
	Service Coordination	**High-Fidelity Wraparound**
Confidentiality	Confidentiality of children/youth and their families involved in the Service Coordination or High-Fidelity Wraparound planning process is protected and all information shared among team members and providers is done so only with a Release of Information (ROI). The Ohio Family and Children First State Office will collect and analyze data on youth/families served through Wraparound and/or Service Coordination to identify trends and address service and supports gaps throughout the state. The ROI must be signed by the responsible family member(s) and/or legal guardian(s). The ROI limits the sharing of information to members of the child and family team identified and authorized by the family. The family and/or guardian will have the right to revoke permission to communicate with any member removed from the child and family team. Service Coordinator/Wraparound Facilitator must follow mandated reporter guidelines, as outlined in section 2151.421 of the Ohio Revised Code. Service Coordinator/Wraparound Facilitator must strive to find the right balance between a family's right to privacy with a team's need for transparency.	

<table>
<tr><td colspan="3">O.R.C. 121.37(C)(7): A procedure for assessing the needs and strengths of any child or family that has been referred to the council for service coordination, including a child whose parent or custodian is voluntarily seeking services, and for ensuring that parents and custodians are afforded the opportunity to participate.</td></tr>
<tr><td rowspan="2">Needs</td><td>Service Coordination</td><td>High-Fidelity Wraparound</td></tr>
<tr><td>Service Coordinator gets to know a family and their story so they can build an understanding of each family's unique needs.</td><td>A hallmark of the Wraparound process is the focus and attention on identifying the underlying unmet needs of youth and families; and understanding that these unmet needs are most often the driving force behind the behaviors of concern.

Facilitators conduct a robust exploration of unmet needs, focusing on the unmet needs of the identified youth, caregivers, and other family members.</td></tr>
<tr><td colspan="2">The family, with the support of the team, chooses which needs to prioritize. As needs are met, new needs are prioritized until the family is ready to transition out of the planning process.

An underlying assumption is that by meeting a family's unmet needs, their quality of life will improve.

It is important to understand the "why" of the behavior before moving too fast to try and solve it.

A helpful concept to remember is that all bad behavior comes from unmet need.</td></tr>
<tr><td rowspan="2">Strengths</td><td>Identify the strengths of the youth/family and use these strengths while developing the service coordination plan.</td><td>Wraparound includes an in-depth exploration of strengths of the youth, family, team, and community. Facilitator strives to identify functional strengths, which can be used and built upon to develop the action steps of the plan.</td></tr>
<tr><td colspan="2">Steps a Service Coordinator/Wraparound Facilitator can take in the process of gathering, promoting and utilizing strengths include:
Set the stage for a friendly and respectful conversation with the youth and family members
Actively attend to the way that each family member tells their story
Formalize understanding of the story through a narrative summary or timeline
Summarize strengths and share with the family and team on an ongoing basis
Develop strength-based plans by selecting options that have the strongest tie to identified strengths</td></tr>
</table>

<table>
<tr><th colspan="3">O.R.C. 121.37(C)(8): A procedure for development of an individual family service coordination plan.</th></tr>
<tr><td rowspan="2">Plan Development</td><td>Service Coordination</td><td>High-Fidelity Wraparound</td></tr>
<tr><td>Service coordination plans are composed of resources from a community array connected to a family in a way that matches current family needs.

Plans are reviewed at least quarterly.</td><td>Wraparound uses team meetings to develop and refine an individualized plan centered around the family’s underlying unmet needs.

The plans contain a blend of formal services, adapted or tailored services, and customized and created responses that are designed for the family.

Wraparound plans are expected to demonstrate a clear tie to the strengths of the youth, family, team members and the community.

Plans include new, highly individualized supports and interventions to meet the underlying, unmet needs of youth and families

Plans are reviewed and updated at every team meeting.</td></tr>
<tr><td colspan="2">Plans will include action steps, person responsible, and a timeline for the completion of tasks.

Teams choose options that are closely linked to identified strengths.

Teams are challenged to be creative and individualized. There is no “one size fits all” when it comes to Service Coordination or Wraparound plan development. Instead, think of it as “one size fits one.”</td></tr>
</table>

Selecting Community Services and Supports

County FCFCs believe that no matter how you are working with families, every family deserves a certain level of expectations in the way they are treated. This is true for all interactions, including identifying, selecting, and connecting to community supports and services. All actions with families should be grounded in these principles:

- **Strength-Based:** All resources, services and supports should be selected and identified based on the unique strengths, talents, assets and resources of the youth, their parents, and other caregiver(s). In all circumstances, every family should have their strengths and interests considered when examining a range of community service options. This will require seeking information about family preferences, capacities, and history to facilitate the right match of community resource.
- **Needs Based**: Families deserve to have helpers get to the root of the challenge. If a Service Coordinator is responding to a simple request for assistance, the responder should slow down to build an understanding of the underlying concern. Taking the time to build an understanding ensures families get matched to the right resource in the right way at the right time.
- **Collaborative:** All decision-making should be made by authentically collaborating with the family. At a minimum, this involves the helper providing transparent information, holding a stance of openness about the family's preferred option, and following through on accessing services and supports that reflect the family's perspective.
- **Family-Determined:** Armed with an understanding of the types of services and supports available and preferred by the family, as well as how effectively and efficiently the service or support is likely to address the particular situation, the youth and family are in a position to determine which services and support strategies are right for them. Helpers should be prepared to not only provide information but make adjustments based on family preferences.

Steps for working with families and others when selecting community services and supports:

1. Identify the type of need for which services and supports are being sought.
    - Is there a Food need? Housing? Transportation? Health? Safety? Security? Social?
2. Clarify the situation in detail; why is it an issue for this family?
    - Be specific: Is there not enough food? Lack of organization or no transportation to get food? Special diet required? Eviction imminent? Lead? Housing required? Jobless? Insufficient income? Lack of friends? No transportation to activities? Unsafe activities?
3. Identify resource options available in the community, taking into consideration individuals, clubs/groups, non-profit organizations, private sector, and public institutions.
    - Once a need is identified and the situation sufficiently clarified, family and team members are guided through a process of brainstorming the people and community groups (informal, public, private, non-profit) that may be helpful in meeting the need.

- Often further information-gathering activities are necessary to generate a sufficiently robust and detailed list for consideration. In those cases, intermediate actions steps are assigned and follow-up meeting(s) scheduled.
    - Meeting(s) should be scheduled at frequent enough intervals to a timely access of resource.
    - Intermediate action steps might include such things as: consulting the 211 data base, county FCFC and/or persons who have used the resource; clarifying eligibility requirements or wait times; meeting with a local business or public official.

4. Evaluate the options
    - Once a list of potential services/supports has been generated, options are evaluated through a series of questions to ensure the resource matches the particular situation:
        - Is this resource likely to be effective in meeting the specific need?
        - Does it address the situation efficiently? How soon?
        - Is it accessible?
        - Does it build on family strengths? Which ones?
        - Does it incorporate the family's already existing interpersonal and community connections? Create new ones?
        - Is it sustainable?
        - What steps are necessary to put this resource in place?
        - What steps are necessary to help the youth and/or family participate?
5. Youth and/or family choose the option(s) right for them
6. Assign action steps
    - Action steps (e.g., making a phone call, transporting a child, arranging an appointment) needed to put the service/support into place are identified and assigned to a specific person/team member for follow-up
        - Care should be taken to ensure that no one individual, particularly the youth and family, is overburdened by the number of action steps assigned.
    - Depending on the action required, a date for starting and/or completing the step is determined.

Selecting Community Resources Worksheet

The following worksheet was developed to accompany this guidance and assist in the process of identifying community services and supports. It is designed specifically to reinforce the logic behind choosing a particular resource. It walks the service coordinator, family and the team through a process that prompts them to 1) think about areas they may not have previously considered and 2) evaluate options for alignment with FCFC principles of being strength-based, collaborative and family focused.

Selecting Community Resources Worksheet

Basic Needs	Support Needs	Service Needs

Child/Youth Name: Click or tap here to enter text. **Family Name:** Click or tap here to enter text.	**Date:** Click or tap here to enter text.	**Summary of Family's Concerns:** Click or tap here to enter text.

Basic Needs Specific Request	Why is this important to the family?	List Local Options		Eligible?	Strategy Check all that apply	Follow-Up Who/When
Choose an item.	Click or tap here to enter text.	Public[17]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private[18]	Click or tap here to enter text.	Choose an item.		
		People[19]	Click or tap here to enter text.			
		Club/Groups[20]	Click or tap here to enter text.	Choose an item.		
		Non-profits[21]	Click or tap here to enter text.	Choose an item.		
Choose an item.	Click or tap here to enter text.	Public	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private	Click or tap here to enter text.	Choose an item.		
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		Club/Groups	Click or tap here to enter text.	Choose an item.		
		Non-profits	Click or tap here to enter text.	Choose an item.		
Choose an item.	Click or tap here to enter text.	Public	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private	Click or tap here to enter text.	Choose an item.		
		People	Click or tap here to enter text.			
		Club/Groups	Click or tap here to enter text.	Choose an item.		
		Non-profits	Click or tap here to enter text.	Choose an item.		
Notes for Next Steps: Click or tap here to enter text.						

[17] Consider federal, state, county or city programs, public health centers, schools & colleges, police, etc.
[18] *Consider youth oriented or local businesses, chamber of commerce, etc.*
[19] *Consider neighbors, friends, relatives, local leaders, mentors, persons associated with the community service/support, etc.*
[20] *Consider Neighborhood & Community Centers, Kiwanis/Rotary, Religious & Cultural organizations, etc.*
[21] Consider counseling & health centers, Salvation Army, etc.

Selecting Community Resources Worksheet

Basic Needs	Support Needs	Service Needs

Child/Youth Name: Click or tap here to enter text. **Family Name:** Click or tap here to enter text.	**Date:** Click or tap here to enter text.	**Summary of Family's Concerns:** Click or tap here to enter text.

Support Needs Specific Request	Why is this important to the family?	List Local Options		Eligible?	Strategy Check all that apply	Follow-Up Who/When
Choose an item.	Click or tap here to enter text.	Public[22]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private[23]	Click or tap here to enter text.	Choose an item.		
		People[24]	Click or tap here to enter text.			
		Club/Groups[25]	Click or tap here to enter text.	Choose an item.		
		Non-profits[26]	Click or tap here to enter text.	Choose an item.		
Choose an item.	Click or tap here to enter text.	Public[22]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private[23]	Click or tap here to enter text.	Choose an item.		
		People[24]	Click or tap here to enter text.			
		Club/Groups[25]	Click or tap here to enter text.	Choose an item.		
		Non-profits[26]	Click or tap here to enter text.	Choose an item.		
Choose an item.	Click or tap here to enter text.	Public[22]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
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[22] *Consider federal, state, county or city programs, public health centers, schools & colleges, police, etc.*
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Service Needs Specific Request	Why is this important to the family?	List Local Options		Eligible?	Strategy Check all that apply	Follow-Up Who /When
Choose an item.	Click or tap here to enter text.	Public[27]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private[28]	Click or tap here to enter text.	Choose an item.		
		People[29]	Click or tap here to enter text.			
		Club/Groups[30]	Click or tap here to enter text.	Choose an item.		
		Non-profits[31]	Click or tap here to enter text.	Choose an item.		
Choose an item.	Click or tap here to enter text.	Public[27]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
		Private[28]	Click or tap here to enter text.	Choose an item.		
		People[29]	Click or tap here to enter text.			
		Club/Groups[30]	Click or tap here to enter text.	Choose an item.		
		Non-profits[31]	Click or tap here to enter text.	Choose an item.		
Choose an item.	Click or tap here to enter text.	Public[27]	Click or tap here to enter text.	Choose an item.	☐ Builds on family strengths ☐ Family preference ☐ Collaboratively decided on ☐ Addresses underlying concern/Need	Click or tap here to enter text.
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[31] *Consider counseling & health centers, Salvation Army, etc.*

Data Collection and Monitoring

Service Coordination

Why Collect Data and Outcomes?

Collecting and monitoring outcomes for county FCFC Service Coordination and the community's system of care has multiple purposes:

- To demonstrate the effectiveness and impact of county FCFC Service Coordination and HFWA to stakeholders and funders;
- For assessment of community resources, services, and programming gaps;
- For assessment of patterns and trends in youth and family needs;
- To inform funding and policy decisions at the local and state levels;
- To provide objective data for quality improvement;
- For the development of state quality benchmarks;
- To show system stakeholders the cost benefits and return on investment of county FCFC Service Coordination and HFWA to their systems;
- To show system partners how county FCFC Service Coordination and HFWA helps them achieve their system mandates; and
- To develop a deeper understanding of youth with multisystem involvement and their families.

Monitoring the Service Coordination process for overall effectiveness in the community and in improving the System of Care

What information do we need?

- Service Coordination outcomes:
  - Living with family, relatives, etc.
  - Movement to less restrictive placement
  - Decreased system involvement
- Local System of Care improvement data:
  - New services implemented and accessible/available
  - New resources available and accessible to youth/families
  - New supports implemented and accessible/available
  - Service, support, and resource gaps identified
  - Improved cross-system relationships

- System access/navigation barriers removed
- Community survey of overall effectiveness of the county FCFC Service Coordination process

How are resources and programming activities reassessed based on what is learned from the youth and families that are being assisted?

Gap Monitoring and Identification

- Service Coordinator/Service Coordinator Supervisor tracking:
    - Were there services, supports, resources, or activities/programming that were identified in the plan but **unavailable** in the community?

      Data Sources:

        - Service coordination plan gaps as identified by the Service Coordinator
        - Catalogue of local resources and programming
            - Services: community behavioral health service array
            - Supports: Youth and Parent Peer support; informal supports
            - Resources: Funding, benefits, basic need supports
            - Activities/Programming: Activities that promote youth development and resilience
    - Are there capacity issues, restrictions, or other limitations or barriers that impact the youth/family's ability to access the service, supports, resources, or activities/programming?

      Data Sources:

        - Youth and family's survey feedback on access, availability, restrictions, barriers/limitations.
        - Youth and family report: Did the youth/family report that the service, supports, resources, and activities/programming were helpful to them?

Trends and Patterns

- Convene community stakeholder working group consisting of youth, parents, providers, representatives from child-serving systems, and service coordination staff
- County FCFC service coordination staff present data and facilitate discussion on commonly identified youth and family **needs**
    - Identify high-volume needs
    - Identify low-volume-high risk needs
    - Identify new and emerging needs and risks

    - Prioritize needs to be addressed
    - Summarize findings
- County FCFC service coordination staff present data on service, support, resource, and programming/activities **gaps and barriers**
    - For each category (services, supports, resources, and programming/activities) identify:
        - Does not exist in our community
        - Exists but not enough capacity
        - Exists but lack resources to implement and sustain
        - Exists but has barriers to access (transportation, eligibility limitations, hours of operation, cost prohibitive, limitations on how much a youth/family can receive, etc.)
        - Prioritize gaps to be addressed
        - Summarize findings.

High Fidelity Wraparound

Fidelity and Quality Management

Measuring fidelity to the wraparound process is about measuring and documenting whether facilitators are accomplishing the delivery of wraparound in a way that aligns with the principles, process, and expectations affiliated with the Ohio wraparound model. Two tools are commonly used in Ohio to help monitor fidelity to the wraparound process. First, the WFI EZ, developed by the NWI, can be used as a tool to generate data relating to fidelity. Secondly, Ohio has developed Practice Level Targets and Supervision Level Targets describing a range from best practice, through acceptable, to unacceptable variation concerning both the direct delivery of the wraparound process and the supervision of the process. Currently, this tool is not designed to yield numeric values, but can be adapted to do so.

A routine component of wraparound programs in Ohio should include the utilization of either or both the WFI EZ and Practice/Supervision Level Targets. Data from these tools should be gathered and reviewed at the program and community level as part of the process of determining whether wraparound is located in the right organizational setting, adherence to the Ohio wraparound model, and is making an impact in the lives of families and community outcomes. Also, local communities should consider tools such as intersystem staff and leadership surveys to help assess and respond to community and system stakeholder challenges in supporting effective wraparound implementation.

Managing Towards Quality

Whereas fidelity of the wraparound process can be measured and monitored through surveys and other "tools" implemented by an organizational structure; quality of the wraparound process can only be monitored through supervision and high levels of agency support. Supervision and support for wraparound facilitators should take place on a weekly basis and focus on the facilitator's implementation of the process rather than a family's overall level of functioning and response to a service. Supervision can be implemented individually with each facilitator, through group supervision, utilizing live observations of family/team meetings and/or family/facilitator interactions. Supervision focuses on multiple levels including: learning and skill refinement, quality monitoring, fidelity monitoring, risk and safety management, monitoring ethical concerns, and professional growth.

A supervisor to facilitator ratio should not exceed 1:6 for non-dedicated supervisors and 1:8 for fully dedicated supervisors. Supervision must be provided by an individual with detailed knowledge and/or experience in the implementation of the wraparound process. Also, a potential supervisor must have a strong understanding of other community systems, system of care principles, and a skill set to enable them to foster strong interagency collaboration. As part of their continual development, supervisors will be required to participate in state offered wraparound trainings, wraparound supervision trainings, and supervisor level learning communities.

Indicators of Plan Quality

The quality of families' individual wraparound plans will also be monitored by supervisors. A high-quality wraparound plan shall reflect a family-driven/youth-guided approach, and shall include the following:

- Evidence that the child/youth and family team completed each step/phase of the Wraparound process, including completion of the strengths, discoveries, needs assessments, crisis plan and/or safety programs, Wraparound plans, outcomes, and the development of the team mission statement.
- Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.
- A strength-based, needs-driven, and culturally relevant Wraparound plan that is stated in the language of the child/youth and family.
- Evidence of regular updates as the needs of the child/youth and family change.
- Any services, supports, and interventions that are provided to the family.
- A mixture of formal and informal support and services.
- An individualized crisis plan and/or safety program that reflects the child's/youth's and family's strengths and culture and seeks to build skills and competencies that reduce risk.
- Measurement of outcomes identifying when transition plans should be developed. Transition plans will address any barriers to completion of Wraparound and identify how services and supports will be maintained after Wraparound has ended.
- Evidence that the child/youth and family team review and measure outcomes on a regular basis.

Outcomes Monitoring and Accountability Mechanisms

This section addresses outcomes monitoring and accountability mechanisms for Ohio HFWA.

Quality Management System: Outcomes and Fidelity

- Entities utilizing HFWA will implement a quality management system for outcome collection and tracking, utilization management, and fidelity adherence.
- Quality improvement mechanisms are implemented based on objective data.

Collecting and monitoring outcomes for HFWA has multiple applications and purposes:

- To demonstrate to stakeholders and funders the effectiveness and impact of Ohio HFWA;
- To inform funding and policy decisions at the local and state levels;

- To provide objective data for quality improvement;
- For the development of state quality benchmarks;
- To show system stakeholders the cost benefit of HFWA to their systems;
- To show system partners how HFWA helps them achieve their system mandates; and
- To develop a deeper understanding of youth with multisystem involvement and their families

Team Level Process Indicators and Outcome Benchmarks

In addition to collecting program and state level outcomes, it is important to develop and monitor team-level benchmarks and outcomes.

Team-level outcome benchmarks: HFWA teams should identify team-level outcome benchmarks and regularly monitor them as part of the ongoing revision cycle inherent in the HFWA practice model. This includes:

- Setting, measuring, and reviewing individualized child/youth and family plan goals monthly;
- Benchmarks composed for individual needs being met in the plan;
- Regular updates of the wraparound plan, as the needs of the child/youth and family change (annual updates alone are not sufficient); and
- Utilizing team-level outcomes to identify when transition plans should be developed.

Team level process indicators: The HFWA team should demonstrate evidence of the completion of each step/phase of the Wraparound process, including:

- Completion of the strengths/culture discoveries;
- Needs assessments;
- Crisis plans/safety programs;
- Development of the team mission statement;
- Wraparound plans; and
- Determination of individualized outcome benchmarks.

Program-Level Outcomes

Entities shall monitor the overall outcomes of the HFWA program by tracking youth and family outcomes across HFWA facilitators. Program-level outcomes require the program to track common data across youth and families served. These data elements should coincide with state-level data elements and outcome tool selected by the state (CANS) to allow for statewide aggregation of data. Staff will be certified in the common outcome tool chosen by the state.

Programs should measure resilience promotion as well as problem reduction (see Risk and Protective Factor Checklist). Resilience promotion factors include:

- **Positive connections and supportive relationships** in key life domains (family, school, neighborhood, community)
  - Nurturing family relationships
  - Positive adult mentors
  - Pro-social peers and activities
- **Competencies**: Skills, Abilities, Talents
  - Problem solving skills
  - Emotional regulation skills
- **Contribution and Participation:** Giving back to others
- **Hope and Optimism:** Positive view of self and future
- Accommodations that facilitate functional success.

And finally, data elements should also be consistent with the National Outcome Measures (NOMS) required for federal Block Grant tracking. NOMS data elements include:

- Symptom reduction;
- Increased school functioning;
- Decreased involvement in juvenile justice system;
- Stability in housing/family/living arrangements;
- Increase in access to services;
- Treatment retention;
- Decreased hospitalizations;
- Increased social connectedness: social supports; pro-social activities and peers;
- Perception of care: satisfaction with services;
- Cost effectiveness; and
- Use of evidence-based practices

The following is an example of the NOMS elements applied to youth.

Youth NOMS/Global Outcomes Discharge (Rating period: Duration of Treatment)					
Agency ID:		**Client ID:**		**Date Opened:** **Date Closed:**	
1.	**Community Stability**	**In home at discharge** **☐Yes ☐No**		**Placement Restrictiveness:** **☐ Move to less restrictive setting** **☐ Move to more restrictive setting**	
2.	**School Functioning**	**# of Suspensions:**	**Expulsion:** **☐Yes ☐ No**	**Attendance:** **☐ Attending ☐ Summer Break ☐ Home Schooled** **Days Truant:**	
3.	**Juvenile Justice**	**# New Felony Charges:**	**# New Misdemeanors:**	**#Probation Violations**	**# Arrests**
4.	**Behavioral Health Hospitalizations**	**# of Hospitalizations:**	**Days Hospitalized:**	**Reason for Hospitalization:** **☐Harm to self ☐Harm to others** **Other (describe):**	
5.	**Risk and safety concerns related to youth's functioning**	**1. Harm to others (describe):** **☐ Decreased Concern ☐ No Change ☐ Increased Concern**			
		2. Harm to self (describe): **☐ Decreased Concern ☐ No Change ☐ Increased Concern**			
		3. AWOL/Running away (describe): **☐ Decreased Concern ☐ No Change ☐ Increased Concern**			
		4. Any Other Risk Concerns (describe): **☐ Decreased Concern ☐ No Change ☐ Increased Concern**			
6.	**Child Safety**	**New Abuse/Neglect Charges: ☐ Physical ☐ Sexual ☐ Neglect**			
7.	**Mental Health Functioning**	**☐Deteriorated ☐No Change ☐ Improved**			
8.	**Substance Use**	**☐Decreased Use ☐No Change ☐Increased Use**			
		# Days abstinent in last 30 days:			
9.	**Social Connectedness**	**Pro-Social Supports/Peers: ☐ None ☐ One ☐ Two ☐ Three or more**			
		Pro-Social Activities: ☐ None ☐ Monthly ☐ Weekly ☐ Two or more times per week			
		Social Support Network: ☐ None ☐ One ☐ Two ☐ Three or more			
10.	**Perception of Care**	**Youth and family rating of being respected, validated, and included in decision-making** **☐ None, minimally ☐ Moderately ☐ Highly**			
11.	**Treatment Retention**	**Completed treatment: ☐Yes ☐No** **☐Lack of engagement in services (within first 30 days)**			
12.	**Access to services**	**Linkage or development of new service or support:** **☐ None ☐ One ☐ Two ☐ Three or more**			
13.	**Cost Benefit**	**Unit cost of HFWA**			

HFWA programs should also measure family and caretaker functional outcomes. These may include the following:

- Family stability: stable housing; stable resources; basic needs met
- Family support network growth
- Decrease of caregiver stressors and strains
- Increase in family's ability to navigate system and advocate for family needs
- Improved family relationships and bonding
- Improved family communication
- Improved family problem solving
- Increased ability of parent/caregiver to manage youth's disability
- Improved quality of life

CANS

The Ohio Children's Initiative CANS can be used for tracking youth and family functioning and overall trajectory and outcomes over time.

State-level Aggregate Impact

It is important to be able to demonstrate the impact of HFWA to state entities and legislators. To determine the effectiveness of HFWA statewide, it is important to have comparability of data. Comparability is achieved by using the same outcome measures with reliable adherence to measurement protocols.

The data collected from HFWA programs can assist the state in identifying and addressing emerging trends, service gaps, and the supports needed to successfully maintain youth with multisystem involvement in the least restrictive environment. In addition, this data can provide much needed descriptive data about youth involved in multiple systems including: 1) depth and breadth of system involvement; 2) services and supports provided; 3) presenting concerns of youth who are placed in more restrictive settings; 4) demographic data; and other data as needed.

System-level Needs Identification

One of the core functions of HFWA in Ohio is to identify local service/support gaps, barriers, and intersystem challenges and communicate this information to the county FCFCs for problem solving. In general, the data should tell us how well our systems collaborate, and if the HFWA teaming process makes a difference in our broader community.

Community-level Accountability

A robust community response to accountability will address several of these levels simultaneously across time. An acceptable community response to accountability may be the maintenance of effort to examine a few of these arenas and levels in relationship to each other over time.

The minimum expectation for communities includes:

- The presence of the ability and commitment, on the part of the host agency and the local intersystem environment, to gather, summarize, analyze, and respond to data about program processes (time from referral to first meeting, average number of meetings/family and others) in a way that acknowledges that WA program function is impacted by many factors not simply the host agency's skill and capacity.

- The commitment by all system partners to:
    - Develop a set of priority agreeable outcomes related to the operation of a WA program; and,
    - Regularly assess, analyze, report these outcomes to each other and the broader community as a whole.

Outcome Collection Timeframes

The county FCFC Wraparound facilitator will comply with the State of Ohio Wraparound evaluation requirements.

- Completion of the Youth NOMS form at intake and every three months until the family graduates from Wraparound. Upon graduation, the facilitator will complete the post-graduation/follow-up Youth NOMS.
- Completion of the Ohio Child and Adolescent Needs and Strengths (CANS) at intake, quarterly, and at graduation.
- Family satisfaction information is to be collected at discharge.
- Team process benchmarks are to be collected monthly.

Outreach and Promotional Materials

A variety of outreach and promotional materials were developed to assist county FCFCs with their mission.

Brochures

Three brochures were developed to assist county FCFCs with outreach.

- An Overview of the Service Coordination Process (primarily targeted for families but could be used for anyone new to the process).
- Ohio Family and Children First Council: A Guide for Community Partners
- An Overview for Professionals Serving Families with Youth Involved in Multiple Systems of Care

How to Connect

Are you the parent or do you work with a youth that receives services from multiple agencies in your county?

Your local county FCFC is the place to start for assessing your needs, determining eligibility for Service Coordination, and coordinating which services can best support you.

To view your county's FCFC contact information, click on the county map at:

https://www.fcf.ohio.gov/Contact-Us/Find-Your-County-FCFC

About OFCF

Ohio Family & Children First (OFCF) is a partnership of:

- State Government
- Local Government
- Community Members
- Families
- Parents
- Youth
- You

OFCF Vision:

Every child and family thrive and succeed within healthy communities.

OFCF Functions:

- **Coordinating Systems & Services** by streamlining, organizing & improving services
- **Engaging & Empowering Families** by supporting parents to be active decision-makers & advocates for children, families, and communities
- **Building Community Capacity** by identifying & addressing the on-going needs of families in our community
- **Sharing Accountability** by monitoring, evaluating & celebrating progress in efforts to assure all families & children thrive

Ohio GOVERNOR'S CHILDREN'S INITIATIVE
OHIO FAMILY AND CHILDREN FIRST

An Overview of the Service Coordination Process

Bringing communities together to . . .

- Meet families where they are at and create a sense of warm welcome ***HELLO***
- Provide ***HELP*** to meet the needs of youth & families,
- Support families as they ***HEAL*** from life's challenges,
- Create conditions for families to move toward a life with ***HOPE***

What is Service Coordination?

Service Coordination is a way to link, organize and arrange services, resources, and supports to assure that families have access to people, places and resources that make a difference for them.

How does Service Coordination work?

Service Coordination brings together all of those working with a youth & family to work together to assure that services are aligned, coordinated and streamlined. The steps in the process include:

Initial Contact: Once a referral is received you will be contacted about your needs and a decision will be made about which of our services might be helpful for you and your family.

Hello: A Service Coordinator will welcome you and your family into the program and explain the process, your rights and confidentiality. You'll be asked to complete intake forms.

Help: You and the Service Coordinator will identify a group of people to work with you to develop a plan to meet your family's needs.

Healing: You and your team will implement the agreements in your plan and meet regularly to review it and make changes if needed.

Hope: As your situation improves, you'll plan for the time when Service Coordination is no longer needed. You'll have the chance to celebrate your family's achievements and next steps.

What is the Purpose of Service Coordination?

Service Coordination works to make sure no child or family falls through the cracks of the service system.

Who & Why does Service Coordination Help?

Who: Families who have children receiving many services with little progress.
Why: *Every family deserves a sense that things are getting better.*

Who: Families that are experiencing behavior that is threatening or destabilizing.
Why: *All families deserve to feel safe.*

Who: Youth who access repeated hospitalizations and/or out-of-home care.
Why: *Families should never have to sacrifice attachment for treatment*

Who: Families whose needs outweigh the resources of one or more systems or are encountering barriers accessing services.
Why: *No family should fall between the cracks of a system*

Who: Families who have different wishes than what is offered.
Why: *Each family deserves to be heard & understood*

What Can You Expect in Service Coordination?

• **Strength-Based:** FCFC will seek out your strengths, aspirations, experience, talents, knowledge & resiliency. We always start with what's right with you, not what's wrong with you

• **Needs Based:** We will help you get to the root of the situation to work on the true cause

• **Collaborative:** We work to make decisions together so that you don't feel on the outside of a decision or that things are being done to you, not with you

• **Family-Determined:** We will ask for your opinion and perspective. You have a say in what is right for you. As helpers, we commit to provide information & make adjustments based on your perspective.

[Insert Local FCFC Logo]

How to Connect

Your local county FCFC is the place to start for assessing a youth and family's needs and determining eligibility for programs, services and funding opportunities described in this brochure.

For information on how to make a referral contact your local FCFC.

To view your County's FCFC Coordinator/Director and Chairperson Contact Information, go to:

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Please direct general inquiries to:

OFCF@jfs.ohio.gov

Ohio Family & Children First Council

Bringing communities together to . . .

Meet families where they are at and create a sense of warm welcome ***HELLO***

Provide ***HELP*** to meet the needs of youth & families,

Support families as they ***HEAL*** from life's challenges,

Create conditions for families to move toward a life with ***HOPE***

Special Focus:
A Guide for Community Partners

What are Family & Children First Councils

County Family & Children First County Councils develop, implement and evaluate coordinated responses to issues pertaining to families and children at both the system and direct service levels.

County Councils support area professionals including case managers, court workers, educators, faith-based community leaders, front-line social service agency staff members, health care providers, mental health professionals, and social workers who are serving families with youth who have complex needs such as:

Who: Families who are involved in multiple systems yet continue to struggle,

Why: *Every family deserves a sense that things are getting better*

Who: Families whose children have aggressive behaviors that require repeated hospitalizations or deeper system involvement,

Why: *All families deserve to feel safe*

Who: Families whose needs outweigh the resources of one or more systems or are encountering barriers accessing services,

Why: *No family should fall between the cracks*

Who: Families who have different wishes than what is offered,

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Programs, Services and Funding

Programs, services and funding opportunities are designed to support youth, families and the staff at local child and family serving agencies throughout Ohio. Upon referral the local FCFC will determine which program is appropriate for the youth and family referred.

Service Coordination and Wraparound
Provide cross-system, team-based approaches for planning and coordinating care for families with youth who are involved with multiple systems or at risk for out-of-home placement.

Service Coordination and Wraparound are not meant to take the place of traditional care management offered by community agencies; but rather, are meant to bring together all those working to support the family to ensure that services are aligned, coordinated, streamlined.

A neutral Facilitator guides participants to ensure the processes are:

• **Family Determined:** Families will be asked their opinion and perspective. Planning will prioritize and reflect family preferences.
• **Strength Based**: Planning identifies the knowledge, skills, and assets of youth, family, other team members and the community.
• **Needs Based:** Facilitators focus on getting to the root of the situation to understand the true cause
Collaborative: Facilitators work with the youth, family, service providers and community members to share their ideas, perspectives and resources to develop and implement a coordinated plan.

Family-Centered Services and Supports
Funding to provide some flexibility with non-clinical services and supports for children, youth and young adults with multiple systemic needs and their families.

Multi System Youth TA-Funding
• **Technical Assistance/Consultation:** can be requested to facilitate coordination of clinically appropriate services, supports, and resources for youth with complex needs and their families.

• **Custody Relinquishment Funding:** may be requested to support children and youth who are at risk for custody relinquishment or have already been relinquished and need services and/or supports to transition to community and/or non-custody settings.

Flexible Funding
Flexible, short-term funding for ancillary community-based services and supports that contribute towards a multi-system involved youth's individualized service plan, family stabilization and/or avoidance of an out-of-home placement when no other funding supply is available. Available in Counties that have chosen to pool local funds.

[Insert Local FCFC Logo]

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[Insert Local FCFC Logo]

An Overview for Professionals Serving Families with Youth Involved in Multiple Systems of Care

Bringing communities together to . . .

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Help Us Help You

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Who: Families whose children have aggressive behaviors that require repeated hospitalizations or deeper system involvement,

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A neutral Facilitator guides participants to ensure the processes are:

• **Family Determined:** Families will be asked their opinion and perspective. Planning will prioritize and reflect family preferences.

• **Strength Based**: Planning identifies the knowledge, skills, and assets of the youth, their family, other team members and the community.

• **Needs Based:** Facilitators focus on getting to the root of the situation to understand the true cause beneath a situation.

• **Collaborative:** Facilitators work with the youth, family, service providers and community members to share their ideas, perspectives, and resources to develop and implement a coordinated plan.

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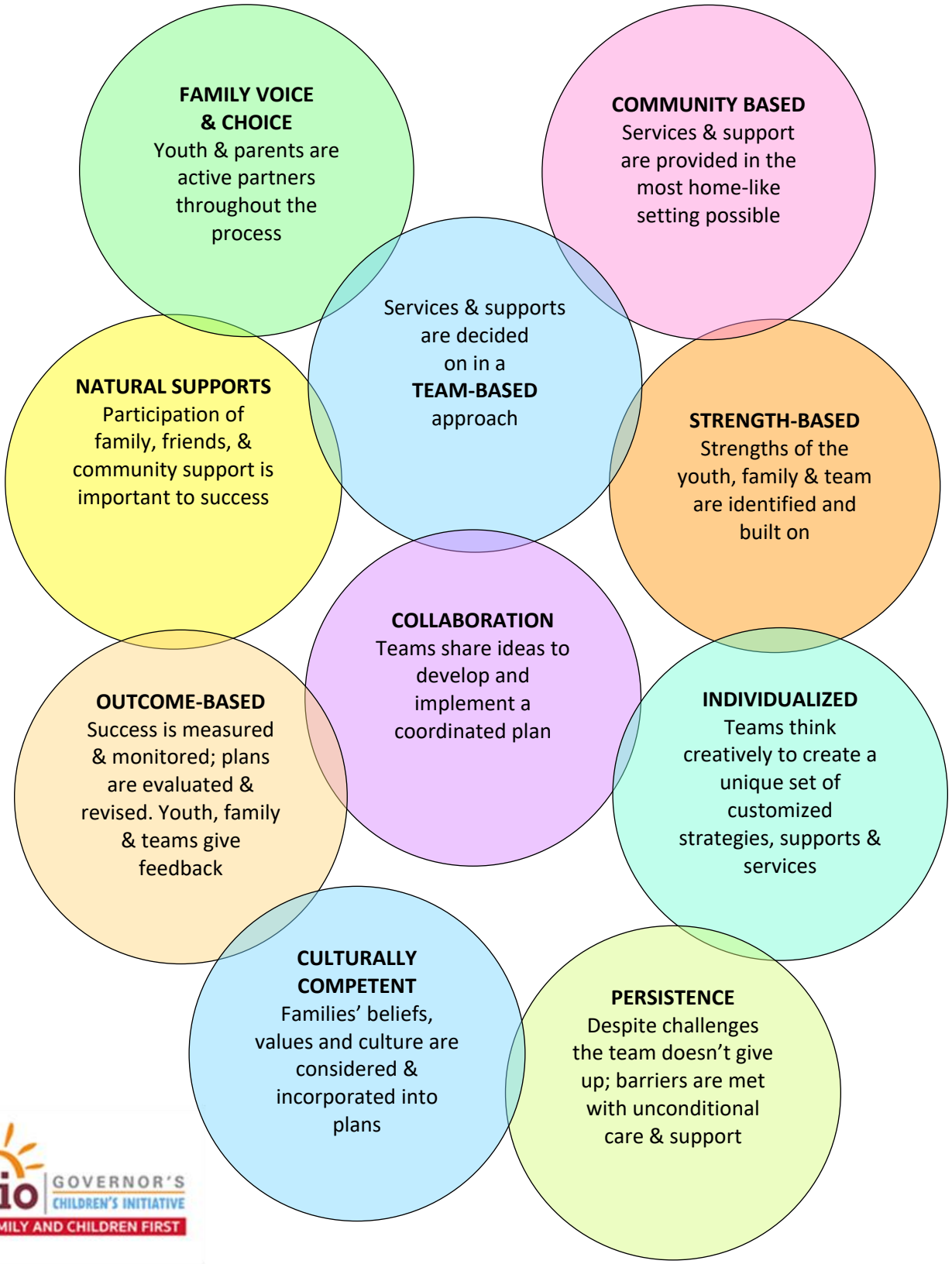
Flexible, short-term funding for ancillary community-based services and supports that contribute towards a multi-system involved youth's individualized service plan, family stabilization and/or avoidance of an out-of-home placement when no other funding supply is available. Available in Counties that have chosen to pool local funds.

One Page Handouts

Four one-page handouts were developed on HFWA to assist families, facilitators, service coordinators, care coordinators and potential county partners in their understanding of the process.

- The Wraparound Process: Guiding Principles
- Stages of the Wraparound Process and Service Coordination
- What Does it Take to Coordinate Care? *Foundational Competencies for Service Coordinators, Care Coordinators and Wraparound Facilitators*
- Teams, Teaming and Team Members in Service Coordination

The Wraparound Process: Guiding Principles



Ohio GOVERNOR'S CHILDREN'S INITIATIVE
OHIO FAMILY AND CHILDREN FIRST

Stages of The Wraparound And Service Coordination Processes

1. INITIAL CONTACT
Once a referral is received, you and your family will be contacted about your needs and a decision will be made about whether Service Coordination or Wraparound Planning might be helpful to you. If you agree, a facilitator will be assigned who will call to schedule a time to to meet you and your family.

2. HELLO
The facilitator will welcome you and your family into Service Coordination or Wraparound. They'll explain the process and talk with you about your family's needs, hopes and dreams. They'll ask you about the people who are important in your life and about any immediate concerns you have. And they'll ask you to sign some forms so the process can begin.

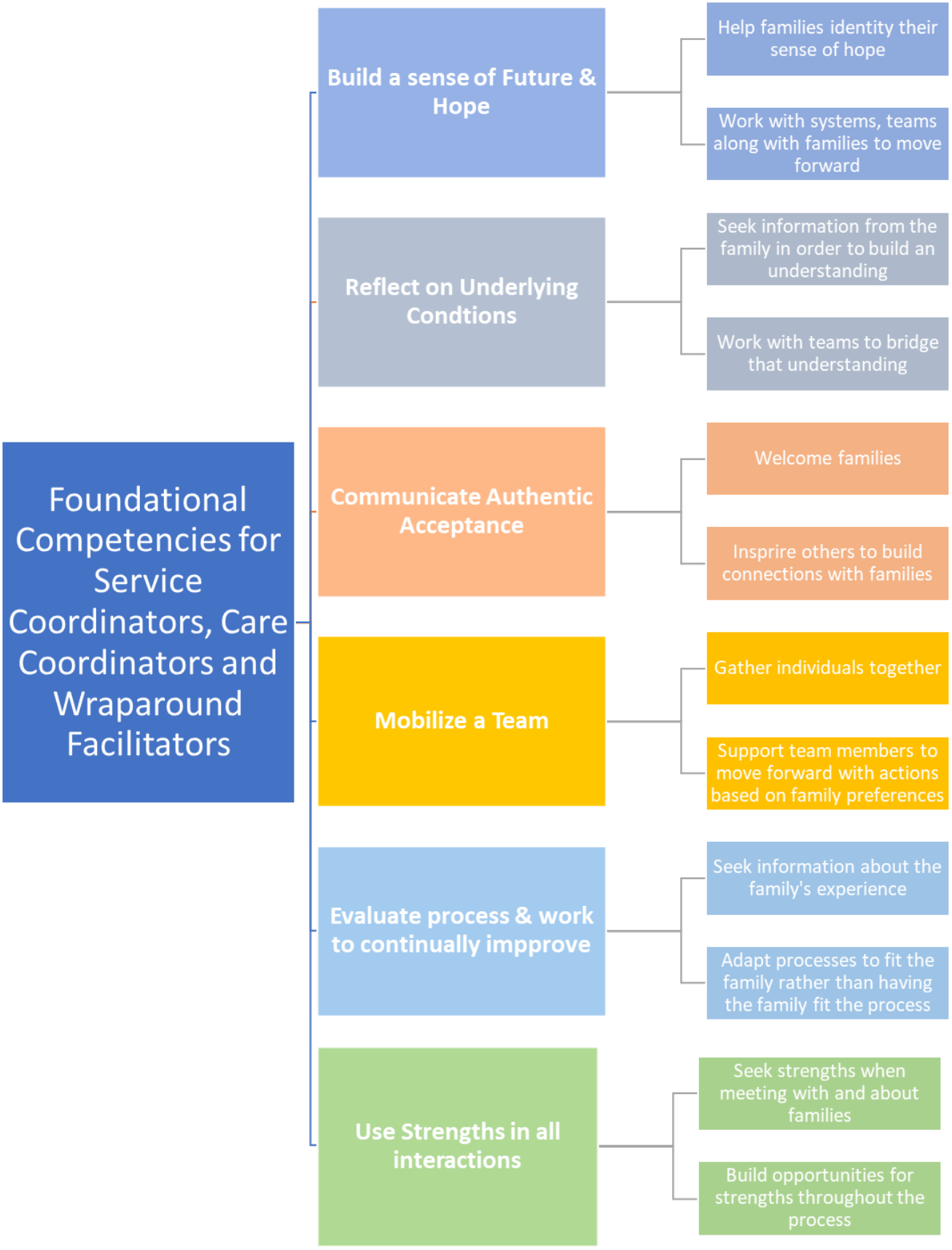
3. HELP
You and your facilitator will pull together a team of people to create a plan to meet the needs you think are most important. You'll decide what to work on, in what order and what actions or services you think will make things better. Everyone will pitch in so you're not doing everything alone.

4. HEALING
You and your team will come together regularly to review the plan, celebrate accomplishments, and make whatever changes are necessary. You'll keep coming together and making changes until the help provided is the right help for you and your family

5. HOPE
As things get better and your family is feeling more hopeful about the future, you and your team will plan for your child's graduation from the program. You'll work with your facilitator and negotiate those services and supports that will continue. As you chart your path forward, you'll also identify how to reconnect should the need arise. As you move forward you will get a chance to celebrate your family's achievements and next steps!

Ohio GOVERNOR'S CHILDREN'S INITIATIVE
OHIO FAMILY AND CHILDREN FIRST

What Does it Take to Coordinate Care?

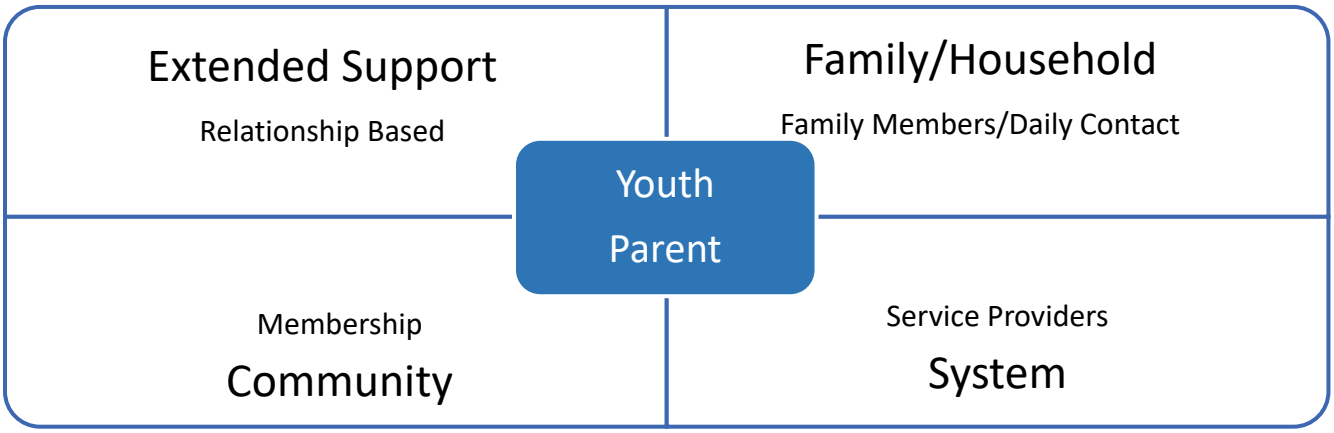


Teams, Teaming and Team Members in Service Coordination

Definitions and Options for Service, Care and Wraparound Coordinators

Service Coordinators don't operate in a vacuum. Their job is to set the stage for communication and to collaborate with others to organize services, supports, community activities and resources around a family's priorities. Effective communication and collaboration must be built upon a foundation of teaming and team building. All Service Coordination must incorporate multiple perspectives in working with families to set up strategies that will support not just accessing services but will support movement toward a family's view of a better life. This involves communication and collaboration with more than service providers. Generally, when we think about Service Coordination there are four sectors that should be considered when identifying patterns of communication and collaboration.

A Connection & Support Map for Coordination



Listed below that are specific examples of team members from each sector.

Family/Household	Extended Support	Community	System
Any member of the youth & parent's household who has daily contact.	Those connected to the family by relationship. These are people who "know" family members & their stories, even though they are unlikely to know the "whole" story.	Individuals connected by membership of an organization which could be geographically based, or association based.	People connected to the family who have a specific goal or role & provide some sort of goal-oriented services.
• Child/Youth • Parent • Stepparents • Extended family or other household members who live in the home	• Extended family • Friends • Co-Workers • Pastor/clergy, if in a relationship • Friends of family • Neighbors	• School staff that all students have access to; librarians, janitors, support staff • Church members • Hobby groups: teams • Community gathering spaces: centers, clubs, groups • Sports teams/gyms • Neighborhood groups	• Therapist • Child Welfare Worker • Probation Officer • Behavioral Specialist • Teacher/Educational staff • Health Care: Physician, Nurse Practitioner

Definitions of Key Terms: Service Coordination and HFWA

Administrative Agent. The financial agent who is designated to handle county FCFC investments, grants, and other monies for FCFC work and to provide oversight of all FCFC activities in partnership with the FCFC.

ADAMHS Board – Alcohol, Drug and Mental Health Services Board. County board that oversees programs addressing alcohol, drug, and mental health services.

Cabinet Council. Cabinet Council comprises the Superintendent of Public Instruction, executive director of the Opportunities for Ohioans with Disabilities Agency, the Medicaid director, and the directors of youth services, job and family services, mental health and addiction services, health, developmental disabilities, aging, rehabilitation and correction, and budget and management. The purpose of the cabinet council is to help families seeking government services. This section shall not be interpreted or applied to usurp the role of parents, but solely to streamline and coordinate existing government services for families seeking assistance for their children.

CANS - Child Adolescent Needs and Strengths. A tool used to identify needs for youth enrolled in Service Coordination or Wraparound.

CPS - Child Protective Services. A division within the county Department of Job and Family Services responsible for receiving referrals and investigating incidents of child abuse, neglect, and dependency in each county.

CSB - Children Service Board. A stand-alone children services agency that is overseen by a board appointed by the county commissioners.

CAO - Community Action Organization/CAC/Community Action Council. A private, non-profit community agency that manages federally and state funded programs like: Home Energy Assistance Program (HEAP), Head Start, Job Training Partnership Act (JTPA), etc.

CME – Care Management Entity. A CME is a community-based organization that serves as the "locus of accountability" for delivering the wraparound model for a specific geographic area of Ohio. CMEs serve as the go-to providers delivering wraparound care coordination for youth enrolled in OhioRISE who have the most complex behavioral health needs. CMEs will also help ground and grow their communities' system of care so overall resources expand to help kids with behavioral health needs and their families in the coming months and years.

Cultural Competency. The understanding of culture as a system of values, beliefs, attitudes, traditions, and standards of behavior governing the organization of people into social groups and regulate both group and individual behaviors is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.[32]

Dispute Resolution. Each county's Service Coordination Mechanism is required to have a Dispute Resolution process as defined in (ORC) 121.37. This is a process that can be used to resolve a conflict between agencies or between parents and agencies to aid in reaching an agreeable solution for each party involved.

[32] https://emanuals.jfs.ohio.gov/FamChild/FCASM/Definitions/5101-2-1-01.stm

EHR - Electronic Health Record. A digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

FCFC - Family and Children First Council. County council required by Ohio Revised Code 121.37 that promotes coordination and collaboration among local governmental social service agencies, non-profit organizations, businesses, and families for the benefit of Ohio's families and children. Among other efforts, they develop local service coordination plans for families and youth with needs across multiple systems and maintain an accountability system which demonstrates progress on achieving OFCF goals. In other words, the council helps families work with several agencies to reach solutions that help children reach their full potential.

FCSS - Family Centered Services and Supports. An Ohio county FCFC funding initiative with the purpose to maintain children and youth in their own homes through the provision of non-clinical, community-based services. Families who have children with multiple systemic needs identified through the county FCFC service coordination process are eligible for FCSS funded services and supports.

FIN - Family Information Network A state-wide system of parent-to-parent networking which provides information and support to families with babies and young children who have developmental challenges or disabilities.

HFWA - High Fidelity Wraparound. An intensive, team-based, individualized care planning and management process that follows a series of steps and considers a set of unique inputs to help children and their families realize a life that reflects their hopes and dreams.

IEP - Individual Education Plan. A federally- required plan developed by school personnel and family to meet a child's special education needs.

Medicaid. The federal medical assistance program that is described in Title XIX of the Social Security Act. Medicaid is administered at the state level and is income or resource based.[33]

MSY - Multi-System Youth. Youth who require services from more than one youth-serving system, which could include children services, developmental disabilities, mental health and addiction, and juvenile justice.

OBM - Office of Budget and Management. OFCF Cabinet Council member that is responsible for preparing the Governor's Executive budget and the capital budget. Also provides fiscal accounting and budget services to state agencies.

OCTF - Ohio Children's Trust Fund. A public funding source in Ohio for child abuse and neglect prevention. https://octf.ohio.gov. OCTF was established to substantially reduce child abuse and neglect in future generations by committing financial resources to prevention efforts in every county in Ohio. This is accomplished through policy formulation and implementation, funding innovative prevention programs, public awareness, and education.

ODODD - Ohio Department of Developmental Disabilities. OFCF Cabinet Council member agency that oversees programs, services, and supports for individuals with developmental disabilities and their families.

[33] https://medicaid.ohio.gov/stakeholders-and-partners/helpfullinks/acronyms-glossary

ODE - Ohio Department of Education. - OFCF Cabinet Council member agency that oversees state education programs. The department's goal is for all students to reach high levels of academic achievement as they become gainfully employed citizens.

ODH - Ohio Department of Health. OFCF Cabinet Council member agency responsible for ensuring the health services of Ohioans.

ODJFS - Ohio Department of Job and Family Services. OFCF Cabinet Council member agency that is responsible for providing leadership to ensure that public assistance, social service, and health programs are administered in a manner that recognizes and preserves individual rights, responsibilities, and dignity so that families, children, and adults are able to restore, maintain or improve their capabilities for self-support and family life. Effective July 1, 2021, ODJFS is the state-level administrative agent for OFCF.

ODM - Ohio Department of Medicaid. OFCF Cabinet Council member that provides health care coverage to more than 3 million Ohioans through a network of more than 165,000 providers.

OhioMHAS - Ohio Department of Mental Health and Addiction Services. OFCF Cabinet Council member with the mission to provide statewide leadership of a high-quality mental health and addiction prevention, treatment and recovery system that is effective and valued by all Ohioans.

ODYS - Ohio Department of Youth Services. OFCF Cabinet Council member agency that is responsible for the safe, secure, and humane confinement and parole supervision of all youth offenders committed by Ohio's 88 juvenile courts.

OFCF - Ohio Family and Children First. State agency that promotes coordination and collaboration among state and local governments, non-profit organizations, businesses, and families for the benefit of Ohio's children and youth.

OhioRise - A specialized Medicaid managed care plan with tailored services to meet the needs of youth with complex needs. OhioRISE aims to shift the system of care and keep more kids and families together by creating new access to in-home and community-based services for youth with the most complex behavioral health challenges.

ORC - Ohio Revised Code. Contains all acts and laws passed by the Ohio General Assembly and signed by the Governor.

OCBF - Operational Capacity Building Funds. A state grant intended to support county FCFC efforts. These dollars may be used to provide a portion of the salary and fringe benefits for county FCFC personnel, parental involvement, administrative support, training, and/or consultation.

OOD - Opportunities for Ohioans with Disabilities. Partners with Ohioans with disabilities to achieve quality employment and independence. They also make determinations on Social Security disability. Currently, a non-statutory member of the OFCF Cabinet Council.

PAC - Parent Advocacy Connection. A program funded through Ohio Family and Children First Cabinet Council and administered through the National Alliance on Mental Illness – Ohio (NAMI Ohio). The program provides parent advocates to families who are interested and are receiving service coordination through their county Family and Children First Council.

PCSAO – Public Children Service Association of Ohio. An association of Ohio's county Public Children Services Agencies that advocates on behalf of the agencies.

Service Coordination. Family focused and strengths-based coordination of services for families with multiple and complex problems to effectively address their needs through an individualized process which eliminates duplication and provides both traditional services and builds natural supports.

SCM - Service Coordination Mechanism. Each county is required to have a Service Coordination Mechanism that includes specific requirements found in Ohio Revised Code (ORC) 121.37 (C)(D) and 121.38. The SCM defines the levels of intervention and coordination across the System of Care Continuum available in each county as a process of service planning and system collaboration for families who have needs across multiple systems.

Shared Plan. A required document developed by FCF Council members that outlines the priority/focus of the work of county FCFCs and must be updated and reported on yearly.

SOC - System of Care. A spectrum of effective, community-based services and supports for children and youth with, or at risk for, mental health or other challenges, and their families, organized into a coordinated network that builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, to help them to function better at home, in school, in the community, and throughout life.

TANF - Temporary Assistance to Needy Families. The federal welfare reform statute approved by congress in the fall of 1996 to give states more flexibility in designing public assistance programs to focus on work first and move welfare recipients into employment. In Ohio, TANF builds on H.B. (House Bill) 167, Ohio's landmark welfare reform legislation approved in July 1995. As under H.B. 167, there is a three-year time limit on cash assistance and an increased emphasis on working with community-based organizations.

WIC - Supplemental feeding programs for Women, Infants and Children. Provides nutrition education, breast feeding support, and nutritious supplemental foods to eligible children and women.

Acknowledgements

This handbook was the result of efforts by OFCF, the Service Coordination Workgroup, and CIP. The following individuals contributed to the writing, reviewing, and/or editing of the handbook.

OFCF

Elisha Cangelosi, Executive Director

Jennie Horner, West Regional Coordinator

Aimee Matusik, East Regional Coordinator

Colleen Tucker, Project Manager

Service Coordination Workgroup Members

Rachilla Basista, Mahoning County

Gretchen Behimer, Clermont County

Veronica Brady and Julie Buzard, Franklin County

Jessica Dunkley, Union County

Melanie Fling and Sylvia Friel, Licking County

Chelsea Freeman, Lorain County

June Green, Pickaway County

Jordan Hodges, Miami County

Janice Houchins, Summit County

Sheila Maggard, Adams County

Robin Martin, Cuyahoga County

Brandy McCoy, Crawford County

Keith McWhite, Lucas County

Lynda Ondre, Brown County

Margaret Osborne, Ottawa County

Cheri Pennington, Morrow County

Brenda Rock, Champaign County

Jennifer Ruetz, Fulton County

Kevin Stevens, Warren County

Linda Trushel, Jefferson County

Julie Voll, Defiance County

Robinlyn Vogel, Ashtabula County

Center for Innovative Practices

Sharon Aungst, Project Manager

Gretchen Behimer, Administrative Expert; FCFC Director

Neil Brown, National Wraparound Expert

Janice Houchins, Administrative Expert; FCFC Director

Laura Domitrovich, Wraparound Facilitator, Supervisor, Administrator, Trainer

Nancy Lowery-Bregar, Ohio Wraparound Facilitator Expert; WA Supervisor

Keith McWhite, Ohio Wraparound Facilitator Expert; WA Supervisor

Pat Miles, National Wraparound Expert

Rick Shepler, Grant Principal Investigator

Rachel Sorg, Ohio Wraparound Facilitator Expert; WA trainer; WA Supervisor